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TITLE PAGE

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Understanding clinician influences and patient perspectives on outpatient discharge decisions: a qualitative study.

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ABSTRACT

Objective

To understand the experience of patients with skin diseases concerning the decision for their discharge from outpatients.

Design

Qualitative study involving observations of consultations and semi-structured interviews with outpatients.

Setting

National Health Service outpatient clinics at a university hospital secondary referral centre.

Participants

64 consultations were observed followed by 56 interviews with patients over 18 years old.

Main outcome measure

Analysis of patients' perspective and expectations concerning whether or not they were discharged.

Results

25 types of influences were observed to be influencing the discharge decision process. All 31 discharged patients appeared to accept the clinicians' decision, however 10 (22%) of those patients later expressed disappointment. Patients' discontent was due to perceived clinicians' uncertainty in diagnosis (patients mentioning = 2), poor acceptance of the diagnosis (2), disease not "cured" (4), differing perception on medical needs (2), lack of concern for job demands (1), felt uninvolved in the decision making (4), feeling rushed (3), prolonged open appointment (2), pushed to seek private care due to healthcare budget constraints (2), language barrier (1), and not keen to continue follow-up with GP (2). Patients were happy when there was certainty of the diagnosis (19), clear treatment plan (16), advised on treatment side effects (7), given a contact number if symptoms recurred (4), considered their travelling and job demands (3). The young adults and working class patients wanted involvement in the discharge process and patients with chronic diseases wanted notification of discharge.

Conclusions

There was a disparity between the patients' and clinicians' perception on what was an appropriate discharge. This included discrepancies concerning diagnostic certainties, the meaning of "cured", private health care as an alternative, the need for easy re-access, and the manner and choice of words surrounding discharge. Medical education should include handling these issues throughout the decision making process.

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STRENGTHS AND LIMITATIONS OF THE STUDY

Strengths

- Data was derived from direct consultation observations by a single observer.
- The qualitative method used, interviewing patients immediately after discharge, encouraged patients' honesty about their experiences, when reassured that their comments would not affect further treatment.
- The usage of a topic guide during interviews focused patients specifically on the discharge decision process.

Limitations

- The study was based in only one centre and may not be a true reflection of discharged patients in general.
- The findings may have been affected by the clinic organisation or local discharge policies where it is possible that clinicians in a less busy clinic with more auxiliary support may interact with patients differently.

MANUSCRIPT

Introduction

Outpatient discharge decision-making occurs across the whole of medicine; it has a critical influence on service efficiency and patient satisfaction but very little is known about it. There are 82.1 million UK outpatient hospital visits annually.[1] At every consultation the clinician takes an implicit or explicit decision to discharge or see the patient again. Clinicians are under pressure to discharge patients to increase capacity.[2] Although strategies [3-5] have aimed at reducing secondary care demand, patients still prefer to see consultants rather than general practitioners (GPs).[6] Clinicians balance their perception of patients' needs, ethical awareness and the intricate influences surrounding discharge in order to take appropriate decisions.[7] Patients' attitudes towards their disease, wishes and their behaviour are also key considerations.[8,9] Clinicians therefore have to contend with complex influences, including possibly inaccurate perception of patients' expectations,[8-10] and the desire to discharge "difficult" patients [8,10,11] while continuing to review patients they know well.[8,9] There is a real risk of biased clinician decision-taking [8,12] .

Few studies[13-16] have examined what outpatients think about their discharge. Seeking to understand patients' views[17-19] may improve patients' discharge experience. Considering patients' wishes over follow-up preference may minimise unneeded appointments. Improved communication [8,9,15,17-19] and explanation of reasons behind discharge[9] may alleviate distress. Lack of planning of care around discharge[15] may result in an unhappy patient and family: incorporating patients' perspectives in the discharge process is critical.[7,8,15-19] The aims of this qualitative study were to observe what influenced clinicians before discharging patients, to explore patients'

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perspectives concerning their discharge or followup decision and to identify what patients think is important for clinicians to consider when taking a discharge decision.

Methods

Participants

South-East Wales Local Research Ethics Committee gave ethical approval. The study took place in the Dermatology Outpatients Department at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by patient interviews. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed. Verbal consent was obtained from patients before consultation observation. As a pilot, eight observations were used to help develop a structured observation recording template (Appendix 1). A checklist of influences was written based on this and on previous clinicians' interviews. [8-10] During each consultation the influences on the decision to discharge were inferred by NAH and recorded using the template. New influences not in the template were added. Immediately after the consultation patients were invited for interview. After giving written consent, patients were interviewed using a topic guide (Appendix 2). At the interview end, a question such as "is there anything more you would like to add?" was asked to encourage further patient ideas. We planned interviewing at least 10 more patients after reaching saturation.

Data collection and analysis

Interviews were transcribed and manually analysed by coding data in the printed transcript margin. Duplications were removed and similar categories grouped and reduced into broader sub-themes. Research team members validated randomly 10% of transcripts against recordings and resolved differences through discussion. Analysis focused on the patients' perception of discharge appropriateness, patients' discharge expectations and what they thought clinicians should consider before discharging them. Transcripts were further analysed using NVivo 10, Qualitative Data Analysis Software to aid data organisation.

Results

All but one consultant agreed to participate. Sixty-four consultations (excluding the pilot) involving seven different consultants were observed. "Discharged due to a wrong referral", identified in the pilot study was added to the template. Fifty-six patients with medical, surgical, subacute and chronic skin conditions were interviewed (26 (46%) male, mean age 54 years, range 18 - 80) (Tables 1 and 2). Data saturation was achieved after 41 interviews: 15 more confirmed saturation. Mean interview time was 20 minutes (range 5-40). NAH undertook all observations and interviews. Patient quotations are given in Appendix 3.

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Table 1 Demographics of study participants interviewed (n=56)

Study Participants	Number	Percentage (%)
Male	26	46
Female	30	54
Age (mean)	53.9 years (18-80)	
Indigenous British	50	89
Ethnic minority	6	11
Education level		
Primary	1	2
Secondary	31	55
Tertiary	24	43
Diagnosis		
Medical	29	52
Surgical	24	43
Unconfirmed diagnosis	3	5
Type of job		
Employed	19	34
Self-employed	4	7
Retired	28	50
University student	3	5
Unemployed on benefits	2	4

Table 2 Skin diseases of patients discharged and followed-up (n=56)

Type of skin diseases	Discharged	Not discharged
Non-melanoma skin cancer	3	4
Melanoma		1
Eczema	1	4
Psoriasis		3
Itchy rash	1	
Acne vulgaris	2	1
Post inflammatory hyperpigmentation	1	1
Actinic keratosis	3	1
Allergic contact dermatitis to latex	1	
Benign mole	2	
Ingrown hair	1	

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Melasma	1	1
Skin cancer and renal transplant		1
Urticaria	2	
Dermatofibroma	1	1
Leg ulcer		1
Onychomycosis	1	
Nodular prurigo		1
Lichen planus	1	
Seborrheic dermatitis	1	
Polymorphic light eruption	3	1
Photosensitive dermatitis, photoaggrevated rosacea and UVA sensitivity	1	2
Insect bites	1	1
Rosacea	2	
Uncertain diagnosis	2	1
Total	31	25

Twenty-five factors were observed to have influenced clinicians' decisions whether to discharge or follow up a patient (Table 3).

Table 3 Observation of what and how factors influence consultants when deciding whether to discharge patients

*GP= General Practitioner

#Quality of life was assessed by asking "How much has your skin bothered you?"

Observed influential factor	**Patient likely to be discharged**	**Patient likely to be followed up**
Type of diagnosis	Disease is self-limiting or simple	Disease is severe or complex
Certainty of the diagnosis	Diagnosis is confirmed	Biopsy is needed to confirm diagnosis
Patient's acceptance of the diagnosis	Understands and able to accept diagnosis	Doubtful about diagnosis accuracy
Type of referral	Wrong referral	Appropriate referral
Joint colleague discussion to confirm diagnosis	Clinician is confident of diagnosis	Joint colleague discussion to confirm diagnosis
Comorbidities	Patient with no other problems	Patient with multiple diagnoses
Guidelines	Treatment which does not involve guidelines	Treatment which involves guidelines (such as for melanoma)

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Disease progression	Stable or asymptomatic	Recurrent
Disease monitoring	Treatment plan which can be monitored by GP	Treatment plan which needs hospital monitoring
Type of treatment	Topical treatment with minimal side effects	Ongoing systemic medication or biologics
Completion of treatment or "cured"	Tumour fully resected	Multiple tumours and recurrent tumours
Joint colleague discussion to confirm diagnosis	Good treatment response	Poor treatment response
Treatment availability	Not available or treatment not possible in the NHS	Many treatment options available in the NHS
Patient age	Younger patients	Older and frail patients
Patient attitude	Patients who appears confident	Patients who have a long term relationship with consultant
Carer	Presence of carer or family	Living alone
Communication	Ability to communicate well	Language barrier
Job	Busy	Retired
Distance	Lives away and travelling difficulties	Easily mobile, independent
Psychosocial concerns	None	Present and could not handle concerns
Skin quality of life	Coping well	Poor quality of life *
Self-manage	Understood well and agreed to self-monitor disease	Difficulties in coping or lack of support to monitor disease
GP relationship	Good relationship with GP	Doubtful of GP's expertise
GP's skills	Skillful GP or GP with dermatosurgical facilities	Perceived inadequate GP dermatology skills
Wishes or concerns	Patient accepts advice after addressing wishes or concern	Unrealistic expectations or too many concerns making it impossible to handle in one clinic setting

The pattern of discharge practice differed depending on various influences. Consultants had their own personal demeanour and unique method when handling discharge: all maintained good eye contact and expressed concern. Twenty-six (46%) consultations were interrupted by colleagues or by phone calls. Consultants kept within the standard consultation time when the problem was simple. However, six consultants spent longer with patients who had special concerns about their skin. Before discharging a patient referred for a diagnosis (after many years of uncertainty), the consultant took time to explain the diagnosis, treatment possibilities and that

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cure was unlikely. When interviewed the patient said she was less anxious, relieved to have a confirmed diagnosis and was happy to be discharged (Quotation 1).

All consultants clearly explained the diagnosis to patients: in two instances the diagnosis was ambiguous but the patient was discharged after reassurance. Patients accepted their discharge readily after a good surgical outcome. An elderly patient appeared relieved when not discharged: she stated that despite normal clinical findings, she was followed up because the consultant had cared for her for years and understood her well. If treatment was complex and needed primary care blood monitoring, consultants tended to check on the patient's motivation to self-monitor. When discharging, one consultant always concluded by asking "Is there anything else I can help you with right now?"

All 31 discharged patients appeared to agree with the clinician's decision to discharge them. However, when interviewed, 12 had not expected discharge. Two of these were happy: one was given the reassurance of easy clinic re-access and the other was relieved the treatment had finished (Quotation 2).

The other 10 patients were unhappy, critical of the clinicians' attitude and incorrect perception of their needs. Eight had chronic disorders and had been followed-up long-term. Only two were at their first appointment. Three patients who had expected to be discharged were given a follow-up: one felt that there were limitations to the consultant's expertise, one perceived that no lesions were recurring and one felt nothing more could be done.

Retired patients were less likely to engage in the discharge discussion. They accepted a more paternalistic approach and were less likely to negotiate follow-up (Quotation 3). When interviewed, only two of the retired patients (7%) preferred to have a discussion over whether or not to be discharged. Patients in employment and young adults apparently felt strongly that they should be involved in the discharge decision and two stated they would inform their consultant if they did not agree with the decision (Quotation 4).

Patients who had chronic or complex problems were keen to be involved in the decision-making and preferred to be notified in advance about the possibility of discharge. Patients with surgical disorders were less demanding, saying they were impressed with the department's services. However, two patients stressed that they should not have been discharged without the dermatology surgeon (preferably) inspecting the surgical wound.

Patients' attitudes to discharge

One patient with acne had not expected discharge despite significant improvement. He assumed he would not be discharged until completion of treatment. But another similar patient was relieved to be discharged, inferring that his disease was controlled. An elderly patient, who experienced slight nerve damage secondary to excision of a skin cancer, agreed to discharge without any concern. However, a university student was dismayed by the decision to discharge, although his facial seborrhoeic dermatitis was clearly improving with medication.

Factors contributing to inappropriate discharge

Uncertainty of diagnosis

Patients insisted that clinicians should confirm their diagnosis before discharge. One patient was unhappy because she felt the clinician was uncertain of the diagnosis. She was asymptomatic because the lesions

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had resolved while waiting for her appointment. She mentioned at the interview that she would have preferred an open appointment for easy access should the symptoms recur rather than a fixed follow-up. However, she did not say this to the clinician. Another patient referred for diagnosis was appropriately given a follow-up. She felt that patients with rare diseases should never be discharged before making a definite diagnosis (Quotation 5).

None-acceptance of the final diagnosis

Two patients stressed that patients' acceptance of their diagnosis is important before discharge. One patient was unhappy because he did not agree with the clinician's diagnosis and expected further investigations and monitoring. He was discharged because the clinician was confident of the diagnosis and explained there was no other treatment. The patient felt that the clinician was only interested in his perception of the diagnosis and was unwilling to probe further (Quotation 6).

Discharge without "curing" the patient

One patient felt that patients with conditions with no cure should never be discharged, because of possible future advances. One student with seborrhoeic dermatitis insisted that his problem must be "cured" despite knowing this condition may recur.

Differing perceptions on medical need and "cosmetic" demand

A patient with melasma was upset because he thought the clinician perceived his problem as purely cosmetic. A young female with acne highlighted that clinicians should provide further suggestions for dealing with disease or treatment complications, such as scarring.

Lack of concern for job demands

One patient stated it was a hassle for her to be discharged and re-referred for surgical intervention if she later wanted this. She expected the clinician to understand her job demands and felt she should have been given more time to make a decision during the consultation. She said she was unable to express her disagreement due to her poor English and had felt uninvolved in the decision-making.

Projecting a "rushed" demeanour

Three patients felt upset because their clinicians appeared rushed. The patients perceived that the clinician wanted to "wrap up" the consultation and discharge them to save time. These patients were still uncertain of their diagnosis or had psychological problems. One patient said he did not express dissatisfaction because of how the clinician spoke (Quotation 7).

Advised to seek private care because of budget constraints

Five patients were unhappy that their clinicians suggested they seek referral to a private dermatologist: actually the clinicians were informing patients about treatment only available in the private sector. Two patients did not understand NHS service limitations and felt the doctor was "following the rules" rather than prioritising the patient's best interests (Quotation 8).

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Four key considerations when taking discharge decisions.

Well informed, certain diagnosis and treatment plan

Patients expected clinicians to be certain of their diagnosis (n=39) and provide a clear treatment plan (n=38). All stressed that providing clear information about their disease, patient information leaflets and website addresses is essential before discharge, empowering self-management and enhancing their confidence. Most patients with chronic diseases felt "safer" to be followed up, in case treatment needed changing. Fifty-one patients expected their management to be complete before discharge, including full investigation, exploring treatments and their responses and a final thorough examination (Quotation 9).

Ascertain patients' ability to cope and self-manage

Patients are reluctant to be discharged if they feel unable to detect subtle changes heralding worsening (Quotation 10). Three psoriasis patients insisted that their disease chronicity meant they should never be discharged, even if well controlled, for fear of coping by themselves or missing new treatments. They felt more reassured being followed up by a dermatologist, even annually, than by their GP (Quotation 11): GPs need to have appropriate knowledge and to know when to re-refer.

Effective patient communication and address concerns

Patients preferred phrases such as: "I don't need to see you again" or "You can now be taken care of by your GP" to the blunter "You are discharged". Fifteen patients said that clinicians should use simple terms when providing information. However during the observations, no clinicians used medical jargon. One (doctor) patient highlighted that clinicians should be reminded not to use medical jargon with a patient, to prevent them being confused (Quotation 12). Eight patients said that, when discharging, it is important that the physician has a confident demeanour to reassure the patient. Three patients mentioned that if a patient does not speak English, an interpreter must be used. During observation, apparently all except two discharged patients understood the diagnosis. One patient noticed the clinician was unimpressed by his spots until told they were itchy, illustrating patients' sensitivity to doctors' mannerisms and body language (Quotation 13). Two patients felt it important that clinicians ask whether patients are happy to be discharged (Quotation 14). However, one patient thought this a redundant question because he did not think anything would have been done if he replied he was unhappy (Quotation 15).

Efficient clinic organization and clinical practice

Seven patients were more likely to accept discharge if assured of quick re-access to specialist care if necessary. Twenty patients felt the long waiting time for first appointments or re-referrals was daunting. One patient with severe chronic urticaria said he almost committed suicide because of intolerable pain and itch and the long delays in dermatology referral (Quotation 16).

Patients were happy if they perceived good communication existed between dermatologists and GPs or other specialty consultants involved in their care. Those with comorbidities were most appreciative of the reassurance that after discharge they would still be in good hands. Five patients mentioned the importance of coordination

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between GP and specialist. Two patients stated that discharge was more acceptable when notice of possible discharge is given during a previous consultation or when, after biopsy, the consultant wrote to the GP confirming a benign diagnosis. However, a (nurse) patient thought otherwise (Quotation 17). Patients with chronic conditions felt that warning of discharge would allow their mental preparation. Two surgical patients were keen to see the clinician who operated on them before discharge, to give them reassurance of the surgery's success and a sense of completeness.

Discussion

Accurate perception and certainty of information

This study has revealed that although most outpatients appeared pleased with the clinicians' discharge decisions, there may be major discordance between what clinicians thought was an appropriate discharge and patients' actual views,[13] similar to other misunderstandings between patients and clinicians.[20] Although clinicians endeavoured to address patients' needs, expressed concern and confidently arranged discharge, they mainly focused on medical concerns[21] and were unaware of some patients' discontent over the discharge itself. Moreover, no patients objected to their discharge. Clinicians may be unwittingly biased because of overconfidence,[8,22] or previous individual experiences.[23] Skilled expertise [24] is central to accurate clinical judgement, however a standardised tool might in some instances be helpful to prevent bias.[8] For example the impact of pruritus on life quality is often underestimated [25] and patients can be inappropriately discharged. The use of a quality-of-life questionnaire may reveal how patients are coping with their problem [26] and inform the discharge decision.

Inpatients are sensitive to subtle nuances of clinicians appearing courteous but not truly curious about patients' expectations and needs. [21] This study identified that outpatients also perceive these nuances, despite short consultations. Clinicians rather focus on the basics of clinical medicine, such as diagnosing and monitoring treatment response. As problematic in the inpatient setting,[15] outpatient clinics are usually very busy and clinicians have little time to make decisions over discharge. Longer consultation times for patients' final visits would allow more detailed addressing of patients' concerns and possibly reduce biased judgements.

Patients expect continuity of outpatient care until the diagnosis is certain, but this may not always be possible. Clinicians should provide relevant information and supply information[8,9] to increase patients' confidence in the discharge process. Jointly discussing a patient's treatment plan and encouraging further questions, [27] even if a patient seems to accept discharge, could uncover unmet needs.

Effective communication and patient engagement

Effective clinician-patient communication is a core attribute of high quality discharge-making.[9,15] Medical jargon should be avoided and an atmosphere created to encourage patients to ask questions.[13] Healthcare professionals should engage patients with chronic conditions as part of the healthcare team and in the discharge decision process. Clinicians should be mindful of their demeanour with patients. Patients emphasised the importance of clinicians projecting confidence, respecting patients' views, using "kinder" words at discharge and displaying empathy. Most dermatology patients left the discharge decision entirely to clinicians. Patient

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involvement should take place,[28] even if disagreeing with the final decision. Clinicians should gauge what matters most to a patient [29] before making a decision. Clinicians may miss subtle hints of patients' needs if they discount patients' personal accounts,[21] dominate a subservient patient or ignore patient involvement in the decision process.[15,30] Conflicting views on the final decision should alert clinicians to try to understand the reasons for disagreement and accept them as potentially valuable in enhancing their clinical judgement.

Addressing concerns and patient reassurance

Ideally patients' concerns should be fully addressed before discharge, but in reality this may be impossible. Some patients felt "short-changed" at not receiving the "best" treatment for conditions with a strong cosmetic element. Aggressive discharge policies or tumour management guidelines may be challenged if patients express uneasiness at not being given a follow-up after surgery. Patient dissatisfaction might be reduced if clinicians ensured that patients understood the reasons behind hospital policies. Easy access to policy documents might enable this, if written in simple language. Dermatology patients are especially vulnerable to public comments of their appearance, because skin is integral to body image and self-respect. Although treatment was often not ideal, many patients interviewed preferred to be indefinitely under the dermatology care. Difficulties arise because of a mis-match between clinicians thinking they have "reassured" a patient and the patient's actual perception.[31]

Long re-referral waiting times add worry to patients already having difficulty coping. Clinicians should be mindful of this and make provision for open return appointments or direct access if needed. If patients are discharged with severe or chronic inflammatory skin disease that needs continued monitoring, a well-coordinated management plan between the specialist and the GP [9,15] must be organised and clearly explained to the patient. Prior notification of discharge may help alleviate anxiety and give reassurance. Patients need reassurance that they will receive quality care after discharge from outpatients.[31] Although some patients favour indefinite secondary care, they should be informed of the framework of care provided by GPs [9] and their suitability for follow up in primary care: clinicians should identify patients who need primary care input or emotional support after discharge.

Implications and future research

The degree to which patients accept discharge varies widely: each patient's level of concern arises from their individual belief system or expectations. Patient engagement in the discharge process could contribute to the appropriateness of discharge decisions. Up to now, the patients' voice in the discharge decision has largely been ignored. However there is increasing motivation to ensure that clinical decisions are efficient and appropriate, to enhance care and for reporting performance. When taking the decision to discharge, clinicians using empathetic body language may help alleviate patients' anxiety. But too much sympathy may invite unnecessary follow-up and discourage some patients to learn to self-manage. The clinical challenges require an appropriate mixture of coaxing and empathy along with the assessment of treatment response and consideration of the diagnosis. We need to train clinicians to think and decide about discharge systematically: clinicians should consider the patient's overall health, the clarity of the treatment plan, the patient's ability to apply treatment and to cope with treatment side effects. The wide range of issues identified by patients as important provides evidence to support targeted clinical training.

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Conclusion

This study provides a warning to clinicians that discharging a patient is even more complicated than it seems, and has opened a Pandora's Box of patients' attitudes surrounding discharge decisions. It highlights the importance of considering patients' perspectives in ensuring the appropriateness of outpatient discharge**.** Clinicians should try to include patients in discharge decisions and understand and address their wishes, especially with dermatology patients whose confidence relates to their body image. There is a need for a systematic approach to develop a science of discharge. We need first to ascertain which information is critical to consider prior to discharge and second, to understand how clinicians can gain an accurate perception of patients' expectations and avoid bias. Conflicting views relating to discharge will continue between some clinicians and patients unless clinicians more fully understand patients' expectations and are able to handle their concerns. Perhaps after beginning to hear the patient's voice surrounding discharge, clinicians should be encouraged to develop the skills needed to take consistently high quality and appropriate discharge decisions.

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Document: Reply to Ms Fay Pearson (Assistant Editor to the BMJ Open)

Date: 15th December 2015

Editor's comments:

Before we can progress with your submission, please complete and include a COREQ check-list, ensuring that all points are included and state the page numbers where each item can be found: the check-list can be downloaded from here: http://www.equator-network.org/reporting-guidelines/coreq/

Corresponding author's reply:

- The COREQ Checklist has been completed
- All points related to the needs of the checklist have been listed and further explained in the manuscript.
- Page numbers where each item can be found have been stated in the checklist

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Table 1 Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

DOMAIN 1: RESEARCH TEAM AND REFLEXIVITY

PERSONAL CHARACTERISTICS

1. Q: **Interviewer/facilitator**: Which author/s conducted the interview or focus group?
   A: Nur Ainita Harun (First author, female researcher) conducted the interviews
   Page: 5, Methods

2. Q: **Credentials**: What were the researcher's credentials? E.g. PhD, MD
   A: MBBS (Malaya), DDSc (Dermatological Sciences, Wales)
   Page: 1, Title page

3. Q: **Occupation**: What was their occupation at the time of the study?
   A: Research fellow (Postgraduate PhD student)
   Page: 1, Title page

4. Q: **Gender**: Was the researcher male or female?
   A: Female
   Page: 5, Methods

5. Q: **Experience and training**: What experience or training did the researcher have?
   A: NAH is a clinician trained in internal medicine and dermatology. NAH received training in qualitative interviewing and transcription analysis, and conducted mock interviews before interviewing participants.
   Page: 5, Methods

RELATIONSHIP WITH PARTICIPANTS

6. Q: **Relationship established**: Was a relationship established prior to study commencement?
   A: No. NAH did not know any of the participants before the study commenced.
   Page: 5, Methods

7. Q: **Participant knowledge of the interviewer**: What did the participants know about the researcher e.g. personal goals, reasons for doing the research?
   A: The participants only knew that NAH was a dermatology clinician who was currently a full time researcher.
   Page: 5, Methods

8. Q: **Interviewer characteristics**: What characteristics were reported about the interviewer/facilitator? Bias, assumptions, reasons and interests in the research topic
   A: NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumption was made that interviewer bias would be minimised by one person carrying out all the interviews.
   Page: 5, Methods

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DOMAIN 2: STUDY DESIGN

THEORETICAL FRAMEWORK

9. Q: **Methodological orientation and Theory:** What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
   A: A thematic analysis underpinned the study: themes were derived from the data and not identified in advance.
   Page: 6, Methods

PARTICIPANT SELECTION

10. Q: **Sampling**: How were participants selected? e.g. purposive, convenience, consecutive, snowball
    A: Participants were selected using a purposive and convenience methodology.
    Page: 5, Methods

11. Q: **Method of approach:** How were participants approached? e.g. face-to-face, telephone, mail, email
    A: After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2).
    Page: 5, Methods

12. Q**: Sample size:** How many participants were in the study?
    A: In the study, 64 consultations were observed and 56 patients were interviewed.
    Page: 5, Methods

13. Q: **Non-participation**: How many people refused to participate or dropped out?
    A: Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.
    Page: 6, Results

SETTING

14. Q**: Setting of data collection:** Where was the data collected? e.g. home, clinic, workplace
    A: The study took place in the dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff.
    Page: 5, Methods

15. Q**: Presence of non-participants:** Was anyone else present besides the participants
    A: Yes. In 17 interviews a family member of the patient was present.
    Page: 6, Results

16. Q: **Description of sample:** What are the important characteristics of the sample?

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A: The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews.
Page: 5, Methods:

DATA SATURATION

17. **Interview guide:** Were questions, prompts, guides provided by the authors?
A: Yes. The observation checklist and patient topic guide are given in Appendices 1 and 2 of the Supplementary file.

18. **Repeat interviews:** Were repeat interviews carried out? If yes, how many?
A: No repeat interviews were carried out and the participants did not provide feedback on the findings.
Page: 5, Methods

19. **Audio/visual recording:** Did the research use audio or visual recording to collect the data?
A: Yes. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and interviews were audiorecorded.
Page: 5, Methods

20. **Field notes:** Were field notes made during and/or after the interview or focus group?
A: Yes. Field notes were made during the interviews and reflective notes made afterwards.
Page: 5, Methods

21. **Duration:** What was the duration of the interviews or focus group?
A**:** Mean interview time was 20 minutes (range 5-40 minutes).
Page: 6, Results

22. Data saturation: Was data saturation discussed?
A**:** Yes. Data saturation was achieved after 41 interviews.
Page: 6, Results

23. **Transcripts returned:** Were transcripts returned to participants for comment and/or correction?
A**:** No. Transcripts were not returned to participants for comment. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion.
Page: 6, Methods

DOMAIN 3: ANALYSIS AND FINDINGS

DATA ANALYSIS

24. **Number of data coders:** How many data coders coded the data?
A: Three of the authors were involved in the data coding
Page: 5, Methods

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25. **Description of the coding tree:** Did authors provide a description of the coding tree?
A: Yes, a description of the coding tree is provided.
Page: Appendix 4 in the supplementary file.

26. **Derivation of themes:** Were themes identified in advance or derived from the data?
A: A thematic analysis underpinned the study: themes were derived from the data and not identified in advance.
Page: 5, Methods

27. **Software:** What software, if applicable, was used to manage the data?
A: N Vivo 10 Qualitative Data Analysis Software
Page: 6, Methods

28. **Participant checking:** Did participants provide feedback on the findings?
A: No. The participants did not provide feedback on the findings.

Page: 5, Methods

REPORTING

29. **Quotations presented**: Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number.
A: Participant quotations are presented. Quotation numbers are used but not participant numbers.
Page: Refer to the manuscript where the quotations are placed.

30. **Data and findings consistent**: Was there consistency between the data presented and the findings?
A: Yes
Page: 9-13

31. **Clarity of major themes:** Were major themes clearly presented in the findings?
A: Yes. These are presented in the Results and the Discussion.
Page: 11-13

32. **Clarity of minor themes:** Is there a description of diverse cases or discussion of minor themes?
A: Yes
Page: 9-10

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ABSTRACT

Objective

To observe the influences on clinicians when discharging patients, to explore patients' perspectives concerning their discharge or follow-up decision and to identify what patients think is important for clinicians to consider when taking a discharge decision.

Design

Qualitative study involving observations of consultations and semi-structured interviews with outpatients.

Setting

National Health Service outpatient clinics at a university hospital secondary referral centre.

Participants

64 consultations were observed followed by 56 interviews with patients over 18 years old.

Main outcome measure

Analysis of patients' perspective and expectations concerning whether or not they were discharged.

Results

25 types of influences were observed to be influencing the discharge decision process. All 31 discharged patients appeared to accept the clinicians' decision, however 10 (22%) of those patients later expressed disappointment. Patients' discontent was due to perceived clinicians' uncertainty in diagnosis (patients mentioning = 2), poor acceptance of the diagnosis (2), disease not "cured" (4), differing perception on medical needs (2), lack of concern for job demands (1), felt uninvolved in the decision making (4), feeling rushed (3), prolonged open appointment (2), pushed to seek private care due to healthcare budget constraints (2), language barrier (1), and not keen to continue follow-up with GP (2). Patients were happy when there was certainty of the diagnosis (19), clear treatment plan (16), advised on treatment side effects (7), given a contact number if symptoms recurred (4), considered their travelling and job demands (3).

Conclusions

This study highlights the importance of accurately perceiving patients' perspectives in ensuring the appropriateness of outpatient discharge. There was a disparity between patients' and clinicians' perception on what was an appropriate discharge. This included discrepancies concerning diagnostic certainties, private health care as an alternative, need for easy re-access and choice of words surrounding discharge. Medical education should include handling these issues.

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STRENGTHS AND LIMITATIONS OF THIS STUDY

Strengths

- Data was derived from direct consultation observations by a single observer.
- The qualitative method used, interviewing patients immediately after discharge, encouraged patients' honesty about their experiences, when reassured that their comments would not affect further treatment.
- The usage of a topic guide during interviews focused patients specifically on the discharge decision process.

Limitations

- The study was based on only one centre and may not be a true reflection of discharged patients in general.
- The findings may have been affected by the clinic organisation or local discharge policies where it is possible that clinicians in a less busy clinic with more auxiliary support may interact with patients differently.
- The finding of inappropriateness of discharge was a largely unexpected outcome of this study and the methodology of the study had not been planned to explore this. A further qualitative study needs to be carried out, focusing on interviewing only patients who were "unhappy" or dissatisfied with their discharge, to explore this important issue further.

MANUSCRIPT

INTRODUCTION

Outpatient discharge decision-making occurs across the whole of medicine; it has a critical influence on service efficiency and patient satisfaction but very little is known about it. There are 82.1 million UK outpatient hospital visits annually.[1] At every consultation the clinician takes an implicit or explicit decision to discharge or see the patient again. Clinicians are under pressure to discharge patients to increase capacity.[2] Although strategies [3-5] have aimed at reducing secondary care demand, patients still prefer to see consultants rather than general practitioners (GPs).[6] Clinicians balance their perception of patients' needs, ethical awareness and the intricate influences surrounding discharge in order to take appropriate decisions.[7] Patients' attitudes towards their disease, wishes and their behaviour are also key considerations.[8,9] Clinicians therefore have to contend with complex influences, including possibly inaccurate perception of patients' expectations,[8-10] and the desire to discharge "difficult" patients [8,10,11] while continuing to review patients they know well.[8,9] There is a real risk of biased clinician decision-taking [8,12] .

Few studies[13-16] have examined what outpatients think about their discharge. Seeking to understand patients' views[17-19] may improve patients' discharge experience. Considering patients' wishes over follow-up preference may minimise unneeded appointments. Improved communication [8,9,15,17-19] and explanation of reasons behind discharge[9] may alleviate distress. Lack of planning of care around

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discharge[15] may result in an unhappy patient and family: incorporating patients' perspectives in the discharge process is critical.[7,8,15-19] The aims of this qualitative study were to observe what influenced clinicians before discharging patients, to explore patients' perspectives concerning their discharge or followup decision and to identify what patients think is important for clinicians to consider when taking a discharge decision.

METHODS

Participants

South-East Wales Local Research Ethics Committee gave ethical approval. The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews. NAH, first author and female researcher conducted the interviews. NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumptions were made that the interviewer biased will be minimised by one person carrying out the interviews. NAH is a clinician trained in internal medicine and dermatology. She received training in qualitative interview and transcription analysis, and conducted mock interviews before interviewing participants. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed.

Sampling

The study participants were selected using both convenience and purposive sampling methods. Selecting a "convenience" sample is the commonly used method of non-probability sampling, recruiting people who are easy to reach. Only those patients who attended the outpatient dermatology clinic sessions were selected. "Purposive" sampling, also known as "selective" or "subjective" sampling, is a type of non-probability sampling technique. As this study was about understanding how adult dermatology outpatients were discharged from the clinic, the participants were selected based on the judgement of the researcher because they were dermatology patients attending outpatient clinics with the likelihood of getting discharged. We considered the optimum sample size of interviewees, being informed by a previous study[16] where saturation of information from interviewees was achieved at the 46th face-to-face interview, and recruited an additional 15 patients to avoid bias and increase the robustness of the data.

The recruitment process

Recruitment strategy was to include a variety of patients of different gender, ages, job and education status and a variety of skin conditions, simple, complex, medical and surgical. The researcher selected clinic sessions which had both surgical and medical patient attendances. Recruitment was aimed at patients who were likely to be discharged. Before each clinic session, the consultant reviewed the patient appointment list and case notes and informed the researcher of patients who were "potential" candidates for the study. The researcher would agree or disagree with the consultants' suggestion based on the demographic characteristics of patients whom she had interviewed earlier, in an attempt to recruit patients

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with a wide range of demographic characteristics and diseases. The cooperation of the consultant was critical because of his/her background knowledge of patients' problems, circumstances, and disease severity. When a patient was called in to the consultation room, the consultant sought verbal consent for the consultation to be observed. The researcher was then introduced to the patient and the patient's agreement reconfirmed. Following the consultation, the consultant would again check the patient's agreement and the researcher then interviewed the patient in a separate room. After each interview the researcher would wait for the consultant to call her in for the next patient. It was difficult to keep a good balance of surgical and medical cases because most of the patients who refused to be interviewed were those with complex, medical skin conditions. NAH did not know any of the participants before the study commenced. The participants only knew that NAH was a dermatology clinician who is currently a full time researcher.

Data collection and analysis

In the study, 64 consultations were observed and 56 patients were interviewed.

Consultation observations

The observations of patients' discharge during the consultations with consultants were used as part of a mixed methods research strategy to compliment the subsequent patient interviews. This study approach has the potential to confirm or contrast findings within a wider study. Extracting what influences the consultants' discharge decision taking process can be difficult because the observer can only make assumptions concerning these influences. In order to make note-taking of observations of consultations more structured, a "Consultation Observation Checklist" was used (see Appendix 1) to record observations of how clinicians took discharge decisions. The checklist was developed based on discharge influences identified in the literature review and from previous clinicians' interviews. [8-10] The checklist was piloted in eight consultation observations and altered based on that experience. New influences not in the template were added. The structured recording of data assisted the subsequent manual analysis of how frequently these influences occurred with each consultant and in relation to the context of the decision being made. After each observation, the researcher looked through each influential factor and related it to the discharge or follow-up decision. The checklist helped us to identify patterns of what clinicians considered most before discharging patients and to understand how different patients were handled. For instance by observing the clinicians' demeanour made it possible to compare how clinicians reacted to different patients during the discharge decision making process. The consultant's demeanour, the patient's verbal and nonverbal responses such as facial expressions were correlated with the list of influential factors. These observations were also interlinked with the clinic ambience and circumstances which occurred during the whole discharge decision making process. For example, one consultant asked an elderly patient whether she could apply the cream at home and be discharged, but the patient insisted on a follow-up because of the lack of assistance since she was living on her own. Each consultation was analysed using this method. Outcomes which were similar were categorised under the same heading (influential factor) as depicted in Table 1. One of the limitations of this data analysis was that categorical data handling may result in a conceptual grid and there may be new categories or influences missed. However, this limitation was addressed by the pilot observation study.

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Patient interviews

Immediately after the consultation patients were invited for interview. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and it was audiorecorded. At the interview end, a question such as "is there anything more you would like to add?" was asked to encourage further patient ideas. We planned interviewing at least 10 more patients after reaching saturation. No repeat interviews were carried out and the participants did not provide feedback on the findings. It would have been ideal for the researcher to interview each consultant immediately after the observation session to confirm whether each factor really had an influence on discharge decision-making process. However, the prime focus of this study was to gain the patients' insights.

Field notes were made during the interviews and reflective notes afterwards. Transcripts were not returned to participants for comment. Three of the authors were involved in the data coding (Appendix 3). Interviews were transcribed and manually analysed by coding data in the printed transcript margin. A thematic analysis underpinned the study and themes were derived from the data and not identified in advance. Duplications were removed and similar categories grouped and reduced into broader sub-themes. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion. Analysis focused on the patients' perception of discharge appropriateness, patients' discharge expectations and what they thought clinicians should consider before discharging them. Transcripts were further analysed using NVivo 10, Qualitative Data Analysis Software to aid data organisation.

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RESULTS

There are no additional data available based on the results provided. Table 1 describes the characteristics of the dermatology consultants who took part in the study. All but one consultant agreed to participate.

Table 1 Demographic characteristics of the consultant dermatologists (N=7)

Consultant Dermatologists	**Number (N)**
Male	5
Female	2
Mean age (range)	50.8 years (38-56)
Indigenous British	4
Ethnic minority	3
Type of NHS Contract	
Full time	7
Part time	0
Also working in private practice	3
Years of clinical experience in dermatology	
30-40 years	2
20-29 years	3
10-19 years	1
< 10 years	1
Main special interest in dermatology	
Medical	4
Surgical	2
Paediatric	1

It is possible that some of the personal characteristics of the consultants, such as age, gender or ethnicity, may have been relevant to the patients' perceptions or acceptance of the discharge decisions. Our study was not designed to address this question, but no patients commented on these personal characteristics of the consultants. During the observation of consultations, the gender, ethnicity and years of experience of consultants were not perceived to relate to patients' satisfaction or dissatisfaction concerning the decision whether or not to discharge them. However one patient with a different ethnic background to the consultant had difficulty understanding the disease management plan and the patient was not discharged. Consultants who worked in private practice appeared to be more confident in providing information to patients if the skin condition was not treatable under the NHS.

Table 2 presents the demographic characteristics of the patients. Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.

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Table 2 Demographic characteristics of the patients who were interviewed and whether they were discharged or not

Study Participants	Number	Percentage (%)	Discharged	Not discharged
Male	26	46		
Female	30	54		
Mean age (range)	53.9 years (18-80)			
Indigenous British	50	89		
Ethnic minority	6	11		
Education level				
Primary	1	2		
Secondary	31	55		
Tertiary	24	43		
Type of skin disease				
Medical	29	52		
Surgical	24	43		
Unconfirmed diagnosis	3	5		
Type of job				
Employed	19	34		
Self-employed	4	7		
Retired	28	50		
University student	3	5		
Unemployed on benefits	2	4		
Diagnosis				
Non-melanoma skin cancer	7	13%	3	4
Melanoma	1	2%		1
Eczema	5	9%	1	4
Psoriasis	3	5%		3
Itchy rash	1	2%	1	
Acne vulgaris	3	5%	2	1
Post inflammatory hyperpigmentation	2	4%	1	1
Actinic keratosis	4	7%	3	1

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Table 2 (continued)

Study Participants	Number	Percentage (%)	Discharged	Not discharged
Allergic contact dermatitis to latex	1	2%	1	
Benign mole	2	4%	2	
Ingrown hair	1	2%	1	
Melasma	2	4%	1	1
Skin cancer and renal transplant	1	2%		1
Urticaria	2	4%	2	
Dermatofibroma	2	4%	1	1
Leg ulcer	1	2%		1
Onychomycosis	1	2%	1	
Nodular prurigo	1	2%		1
Lichen planus	1	2%	1	
Seborrheic dermatitis	1	2%	1	
Polymorphic light eruption	4	7%	3	1
Photosensitive dermatitis, photoaggrevated rosacea and UVA sensitivity	3	5%	1	2
Insect bites	2	4%	1	1
Rosacea	2	4%	2	
Uncertain diagnosis	3	5%	2	1
Total	56	100%	31	25

In 17 interviews a family member of the patient was present. “Discharged due to a wrong referral”, identified in the pilot study was added to the template. Fifty-six patients with medical, surgical, subacute and chronic skin conditions were interviewed (26 (46%) male, mean age 54 years, range 18 - 80). Data saturation was achieved after 41 interviews: 15 more confirmed saturation. Mean interview time was 20 minutes (range 5-40 minutes). NAH undertook all observations and interviews. Patient quotations are given in Appendix 4.

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Table 3 presents the observation of what and how factors influence consultants when deciding whether to discharge patients. Twenty-five factors were observed to have influenced clinicians' decisions whether to discharge or follow up a patient.

Table 3 Observation of what and how factors influence consultants when deciding whether to discharge patients

*GP= General Practitioner

Observed influential factor	**Patient likely to be discharged**	**Patient likely to be followed up**
Type of diagnosis	Disease is self-limiting or simple	Disease is severe or complex
Certainty of the diagnosis	Diagnosis is confirmed	Biopsy is needed to confirm diagnosis
Patient's acceptance of the diagnosis	Understands and able to accept diagnosis	Doubtful about diagnosis accuracy
Type of referral	Wrong referral	Appropriate referral
Joint colleague discussion to confirm diagnosis	Clinician is confident of diagnosis	*Clinician is unsure of diagnosis, needing joint colleague discussion to confirm diagnosis*
Comorbidities	Patient with no other problems	Patient with multiple diagnoses
Guidelines	Treatment which does not involve guidelines	Treatment which involves guidelines (such as for melanoma)
Disease progression	Stable or asymptomatic	Recurrent
Disease monitoring	Treatment plan which can be monitored by GP	Treatment plan which needs hospital monitoring
Type of treatment	Topical treatment with minimal side effects	Ongoing systemic medication or biologics
Completion of treatment or "cured"	Tumour fully resected	Multiple tumours and recurrent tumours
Joint colleague discussion to confirm diagnosis	Good treatment response	Poor treatment response
Treatment availability	Not available or treatment not possible in the NHS	Many treatment options available in the NHS
Patient age	Younger patients	Older and frail patients
Patient attitude	Patients who appears confident	Patients who have a long term relationship with consultant
Carer	Presence of carer or family	Living alone
Communication	Ability to communicate well	Language barrier
Job	Busy	Retired
Distance	Lives away and travelling	Easily mobile, independent

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	difficulties	
Psychosocial concerns	None	*Present and lack of resources to handle concerns*
Skin disease burden	Coping well	*Not coping well.*
Self-manage	Understood well and agreed to self-monitor disease	Difficulties in coping or lack of support to monitor disease
GP relationship	Good relationship with GP	Doubtful of GP's expertise
GP's skills	Skillful GP or GP with dermatosurgical facilities	Perceived inadequate GP dermatology skills
Wishes or concerns	Patient accepts advice after addressing wishes or concern	Unrealistic expectations or too many concerns making it impossible to handle in one clinic setting

Consultation discourse and pattern of discharge

The pattern of discharge practice differed depending on various influences. Consultants had their own personal demeanour and unique method when handling discharge: all maintained good eye contact and expressed concern. Twenty-six (46%) consultations were interrupted by colleagues or by phone calls. Consultants kept within the standard consultation time when the problem was simple. However, six consultants spent longer with patients who had special concerns about their skin. Before discharging a patient referred for a diagnosis (after many years of uncertainty), the consultant took time to explain the diagnosis, treatment possibilities and that cure was unlikely. When interviewed the patient said she was less anxious, relieved to have a confirmed diagnosis and was happy to be discharged (Quotation 1). The possible implications to this finding require further thought and development of strategies to improve clinic discharge management by reducing disruption of clinic consultations. As part of a wider study[8] 40 consultants were asked about the strategies that could be used to improve discharge decision taking: one of these was to train juniors in effective time management.

All consultants clearly explained the diagnosis to patients: in two instances the diagnosis was ambiguous but the patient was discharged after reassurance. Patients accepted their discharge readily after a good surgical outcome. An elderly patient appeared relieved when not discharged: she stated that despite normal clinical findings, she was followed up because the consultant had cared for her for years and understood her well. If treatment was complex and needed primary care blood monitoring, consultants tended to check on the patient's motivation to self-monitor. When discharging, one consultant always concluded by asking "Is there anything else I can help you with right now?"

All 31 discharged patients appeared to agree with the clinician's decision to discharge them. However, when interviewed, 12 had not expected discharge. Two of these were happy: one was given the reassurance of easy clinic re-access and the other was relieved the treatment had finished (Quotation 2).

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The other 10 patients were unhappy, critical of the clinicians' attitude and incorrect perception of their needs. Eight had chronic disorders and had been followed-up long-term. Only two were at their first appointment. Three patients who had expected to be discharged were given a follow-up: one felt that there were limitations to the consultant's expertise, one perceived that no lesions were recurring and one felt nothing more could be done.

Retired patients were less likely to engage in the discharge discussion. They accepted a more paternalistic approach and were less likely to negotiate follow-up (Quotation 3). When interviewed, only two of the retired patients (7%) preferred to have a discussion over whether or not to be discharged. Patients in employment and young adults apparently felt strongly that they should be involved in the discharge decision and two stated they would inform their consultant if they did not agree with the decision (Quotation 4).

Patients who had chronic or complex problems were keen to be involved in the decision-making and preferred to be notified in advance about the possibility of discharge. Patients with surgical disorders were less demanding, saying they were impressed with the department's services. However, two patients stressed that they should not have been discharged without the dermatology surgeon (preferably) inspecting the surgical wound.

Patients' attitudes to discharge

One patient with acne had not expected discharge despite significant improvement. He assumed he would not be discharged until completion of treatment. But another similar patient was relieved to be discharged, inferring that his disease was controlled. An elderly patient, who experienced slight nerve damage secondary to excision of a skin cancer, agreed to discharge without any concern. However, a university student was dismayed by the decision to discharge, although his facial seborrhoeic dermatitis was clearly improving with medication.

Factors contributing to inappropriate discharge

The results contributing to "Factors contributing to inappropriate discharge" were not extracted only from the ten "unhappy" patients but also from other patients who took part in the study.

Uncertainty of diagnosis

Patients insisted that clinicians should confirm their diagnosis before discharge. One patient was unhappy because she felt the clinician was uncertain of the diagnosis. She was asymptomatic because the lesions had resolved while waiting for her appointment. She mentioned at the interview that she would have preferred an open appointment for easy access should the symptoms recur rather than a fixed follow-up. However, she did not say this to the clinician. Another patient referred for diagnosis was appropriately given a follow-up. She felt that patients with rare diseases should never be discharged before making a definite diagnosis (Quotation 5).

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None-acceptance of the final diagnosis

Two patients stressed that patients' acceptance of their diagnosis is important before discharge. One patient was unhappy because he did not agree with the clinician's diagnosis and expected further investigations and monitoring. He was discharged because the clinician was confident of the diagnosis and explained there was no other treatment. The patient felt that the clinician was only interested in his perception of the diagnosis and was unwilling to probe further (Quotation 6).

Discharge without "curing" the patient

One patient felt that patients with conditions with no cure should never be discharged, because of possible future advances. One student with seborrhoeic dermatitis insisted that his problem must be "cured" despite knowing this condition may recur.

Differing perceptions on medical need and "cosmetic" demand

A patient with melasma was upset because he thought the clinician perceived his problem as purely cosmetic. A young female with acne highlighted that clinicians should provide further suggestions for dealing with disease or treatment complications, such as scarring.

Lack of concern for job demands

One patient stated it was a hassle for her to be discharged and re-referred for surgical intervention if she later wanted this. She expected the clinician to understand her job demands and felt she should have been given more time to make a decision during the consultation. She said she was unable to express her disagreement due to her poor English and had felt uninvolved in the decision-making.

Projecting a "rushed" demeanour

Three patients felt upset because their clinicians appeared rushed. The patients perceived that the clinician wanted to "wrap up" the consultation and discharge them to save time. These patients were still uncertain of their diagnosis or had psychological problems. One patient said he did not express dissatisfaction because of how the clinician spoke (Quotation 7).

Advised to seek private care because of budget constraints

Five patients were unhappy that their clinicians suggested they seek referral to a private dermatologist: actually the clinicians were informing patients about treatment only available in the private sector. Two patients did not understand NHS service limitations and felt the doctor was "following the rules" rather than prioritising the patient's best interests (Quotation 8).

Four key considerations when taking discharge decisions

Well informed, certain diagnosis and treatment plan

Patients expected clinicians to be certain of their diagnosis (n=39) and provide a clear treatment plan (n=38). All stressed that providing clear information about their disease, patient information leaflets and website addresses is essential before discharge, empowering self-management and enhancing their

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confidence. Most patients with chronic diseases felt "safer" to be followed up, in case treatment needed changing. Fifty-one patients expected their management to be complete before discharge, including full investigation, exploring treatments and their responses and a final thorough examination (Quotation 9).

Ascertain patients' ability to cope and self-manage

Patients are reluctant to be discharged if they feel unable to detect subtle changes heralding worsening (Quotation 10). Three psoriasis patients insisted that their disease chronicity meant they should never be discharged, even if well controlled, for fear of coping by themselves or missing new treatments. They felt more reassured being followed up by a dermatologist, even annually, than by their GP (Quotation 11): GPs need to have appropriate knowledge and to know when to re-refer.

Effective patient communication and address concerns

Patients preferred phrases such as: "I don't need to see you again" or "You can now be taken care of by your GP" to the blunter "You are discharged". Fifteen patients said that clinicians should use simple terms when providing information. However during the observations, no clinicians used medical jargon. One (doctor) patient highlighted that clinicians should be reminded not to use medical jargon with a patient, to prevent them being confused (Quotation 12). Eight patients said that, when discharging, it is important that the physician has a confident demeanour to reassure the patient. Three patients mentioned that if a patient does not speak English, an interpreter must be used. During observation, apparently all except two discharged patients understood the diagnosis. One patient noticed the clinician was unimpressed by his spots until told they were itchy, illustrating patients' sensitivity to doctors' mannerisms and body language (Quotation 13). Two patients felt it important that clinicians ask whether patients are happy to be discharged (Quotation 14). However, one patient thought this a redundant question because he did not think anything would have been done if he replied he was unhappy (Quotation 15).

Efficient clinic organization and clinical practice

Seven patients were more likely to accept discharge if assured of quick re-access to specialist care if necessary. Twenty patients felt the long waiting time for first appointments or re-referrals was daunting. One patient with severe chronic urticaria said he almost committed suicide because of intolerable pain and itch and the long delays in dermatology referral (Quotation 16).

Patients were happy if they perceived good communication existed between dermatologists and GPs or other specialty consultants involved in their care. Those with comorbidities were most appreciative of the reassurance that after discharge they would still be in good hands. Five patients mentioned the importance of coordination between GP and specialist. Two patients stated that discharge was more acceptable when notice of possible discharge is given during a previous consultation or when, after biopsy, the consultant wrote to the GP confirming a benign diagnosis. However, a (nurse) patient thought otherwise (Quotation 17). Patients with chronic conditions felt that warning of discharge would allow their mental preparation. Two surgical patients were keen to see the clinician who operated on them before discharge, to give them reassurance of the surgery's success and a sense of completeness.

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DISCUSSION

In this study the mean age of patients was 54 years. 55% of dermatology outpatients range from age 45-100 years old. [20] Forty-three percent of the patients interviewed reported having had tertiary education. This is a higher level than the general population. This may be partially explained by the recruitment hospital being based in a large city centre where residents are generally well educated.

Accurate perception and certainty of information

This study has revealed that although most outpatients appeared pleased with the clinicians' discharge decisions, there may be major discordance between what clinicians thought was an appropriate discharge and patients' actual views,[13] similar to other misunderstandings between patients and clinicians.[21] Although clinicians endeavoured to address patients' needs, expressed concern and confidently arranged discharge, they mainly focused on medical concerns[22] and were unaware of some patients' discontent over the discharge itself. Moreover, no patients objected to their discharge. Clinicians may be unwittingly biased because of overconfidence,[8,23] or previous individual experiences.[24] Skilled expertise [25] is central to accurate clinical judgement, however a standardised tool might in some instances be helpful to prevent bias.[8] For example the impact of pruritus on life quality is often underestimated [26] and patients can be inappropriately discharged. The use of a quality-of-life questionnaire may reveal how patients are coping with their problem [27] and inform the discharge decision. Although the use of a quality-of-life questionnaire may be useful to measure patients' quality of life and to highlight particular issues of importance to patients, consultants should always have a keen eye on patient's subjective experience of their disease and its treatment, including the impact on the patient of having to wait for appointments for a re-referral or how their skin problem and its management could affect their work.

Inpatients are sensitive to subtle nuances of clinicians appearing courteous but not truly curious about patients' expectations and needs. [22] This study identified that outpatients also perceive these nuances, despite short consultations. Clinicians rather focus on the basics of clinical medicine, such as diagnosing and monitoring treatment response. As problematic in the inpatient setting,[15] outpatient clinics are usually very busy and clinicians have little time to make decisions over discharge. Longer consultation times for patients' final visits would allow more detailed addressing of patients' concerns and possibly reduce biased judgements.

Patients expect continuity of outpatient care until the diagnosis is certain, but this may not always be possible. Clinicians should provide relevant information and supply information[8,9] to increase patients' confidence in the discharge process. Jointly discussing a patient's treatment plan and encouraging further questions, [28] even if a patient seems to accept discharge, could uncover unmet needs.

Effective communication and patient engagement

Effective clinician-patient communication is a core attribute of high quality discharge-making.[9,15] Medical jargon should be avoided and an atmosphere created to encourage patients to ask questions.[13] Healthcare professionals should engage patients with chronic conditions as part of the healthcare team and in the discharge decision process. Clinicians should be mindful of their demeanour with patients. Patients emphasised the importance of clinicians projecting confidence, respecting patients' views, using "kinder"

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words at discharge and displaying empathy. Most dermatology patients left the discharge decision entirely to clinicians. Patient involvement should take place,[29] even if disagreeing with the final decision. Clinicians should gauge what matters most to a patient [30] before making a decision. Clinicians may miss subtle hints of patients' needs if they discount patients' personal accounts,[22] dominate a subservient patient or ignore patient involvement in the decision process.[15,31] Conflicting views on the final decision should alert clinicians to try to understand the reasons for disagreement and accept them as potentially valuable in enhancing their clinical judgement.

Addressing concerns and patient reassurance

Ideally patients' concerns should be fully addressed before discharge, but in reality this may be impossible. Some patients felt "short-changed" at not receiving the "best" treatment for conditions with a strong cosmetic element. Aggressive discharge policies or tumour management guidelines may be challenged if patients express uneasiness at not being given a follow-up after surgery. Patient dissatisfaction might be reduced if clinicians ensured that patients understood the reasons behind hospital policies. Easy access to policy documents might enable this, if written in simple language. Dermatology patients are especially vulnerable to public comments of their appearance, because skin is integral to body image and self-respect. Although treatment was often not ideal, many patients interviewed preferred to be indefinitely under the dermatology care. Difficulties arise because of a mis-match between clinicians thinking they have "reassured" a patient and the patient's actual perception.[32]

Long re-referral waiting times add worry to patients already having difficulty coping. Clinicians should be mindful of this and make provision for open return appointments or direct access if needed. If patients are discharged with severe or chronic inflammatory skin disease that needs continued monitoring, a well-coordinated management plan between the specialist and the GP [9,15] must be organised and clearly explained to the patient. Prior notification of discharge may help alleviate anxiety and give reassurance. Patients need reassurance that they will receive quality care after discharge from outpatients.[32] Although some patients favour indefinite secondary care, they should be informed of the framework of care provided by GPs [9] and their suitability for follow up in primary care: clinicians should identify patients who need primary care input or emotional support after discharge.

IMPLICATIONS AND FUTURE RESEARCH

The degree to which patients accept discharge varies widely: each patient's level of concern arises from their individual belief system or expectations. Patient engagement in the discharge process could contribute to the appropriateness of discharge decisions. Up to now, the patients' voice in the discharge decision has largely been ignored. However there is increasing motivation to ensure that clinical decisions are efficient and appropriate, to enhance care and for reporting performance. When taking the decision to discharge, clinicians using empathetic body language may help alleviate patients' anxiety. But too much sympathy may invite unnecessary follow-up and discourage some patients to learn to self-manage. The clinical challenges require an appropriate mixture of coaxing and empathy along with the assessment of treatment response and consideration of the diagnosis. We need to train clinicians to think and decide about discharge systematically: clinicians should consider the patient's overall health, the clarity of the treatment plan, the patient's ability to apply treatment and to cope with treatment side

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effects. The wide range of issues identified by patients as important provides evidence to support targeted clinical training.

CONCLUSION

This study highlights the importance of accurately perceiving patients' perspectives in ensuring the appropriateness of outpatient discharge. This study provides a warning to clinicians that discharging a patient is even more complicated than it seems, and has opened a Pandora's Box of patients' attitudes surrounding discharge decisions. It highlights the importance of considering patients' perspectives in ensuring the appropriateness of outpatient discharge**.** Clinicians should try to include patients in discharge decisions and understand and address their wishes, especially with dermatology patients whose confidence relates to their body image. There is a need for a systematic approach to develop a science of discharge. We need first to ascertain which information is critical to consider prior to discharge and second, to understand how clinicians can gain an accurate perception of patients' expectations and avoid bias. Conflicting views relating to discharge will continue between some clinicians and patients unless clinicians more fully understand patients' expectations and are able to handle their concerns. Perhaps after beginning to hear the patient's voice surrounding discharge, clinicians should be encouraged to develop the skills needed to take consistently high quality and appropriate discharge decisions.

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SUPPLEMENTARY FILE: APPENDICES

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Appendix 1

Consultation Observation Checklist

Factors Influencing Discharge Decisions in Outpatient Dermatology

Observation of Dermatology Consultations

Observer: Non participant

Date	
Patient Demographics	
Age	
First visit or follow up	
Discharged or follow up	
Length of consultation	
Diagnosis	
Medical	
Surgical	
Sex	
Ethnicity	
Education level	
Employment Status	
Factors which influence clinicians'' discharge decisions	N= Number of consultations in which the influences were observed
DISEASED BASED INFLUENCE	
Type of diagnosis	
Certainty of the diagnosis	
Severity of the disease	
Disease progression	
Comorbidities	
Type of treatment	
Response of treatment	
Completion of treatment	
Treatment side effects	
Disease monitoring	
Usage of dermatology treatment guidelines	
PATIENT BASED INFLUENCE	
Age	
Gender	
Culture	
Language barrier	
Mobility	
Distance	
Circumstances surrounding patient's life	
Carer	
Cognitive ability	

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Learning difficulties	
Psychological concerns	
Patient's quality of life (how was it assessed?)	
Understanding of the disease	
Patient's acceptance of disease	
Patient's ability self-manage treatment	
Patient's compliance to medication	
Patients' initiative to engage with support with groups	
Patient's concerns	
Patient's wishes	
PRACTICE BASED INFLUENCE	
Academic interest	
Reassure patient easy reaccess to secondary care	
Joint colleague discussion	
Nurse assisted in explaining treatment	
Ascertain patient-GP relationship	
Ascertain GP's skills in handling dermatology cases	
Ascertain GP's willingness to share care	
Ascertaining availability of treatment in secondary care	
Discharge due to wrong referral	

Reflection box

How was the consultant's demeanour? _____

Did the clinician show information leaflets? _____

Was there medical jargon when explaining to the patient? _____

Did the clinician notify the patient of a possible discharge in the next visit? _____

Further comments: _____

Note:

Definition of some terms used

"Understanding and acceptance of diagnosis by the patient".

This was assumed by the observer noting that patients nodded and smiled and told the consultants that they understood and accepted the diagnosis when asked by some of the consultants.

"Acceptance of disease by the patient". This was assumed by the observer if the patient nodded in agreement and agreed with the diagnosis told by the consultant.

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"Understanding of disease by the patient". This was assumed by the observer if the patients nodded, smiled and said "yes" when asked whether they understood what the diagnosis was and how to take or apply medication.

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Appendix 2

Patient Interview Guide

Factors Influencing Discharge Decisions in Outpatient Dermatology

Introduction

The research student will introduce herself and thank the patient for considering on being part of the study. She will give a copy of the patient information sheet to the participant to read and she will also go through any queries pertaining to their participation in the study. If the patient agrees to be interviewed, then the patient will have to sign a consent form. Both the patient and the carer will be informed that the interview will be audio recorded and some statements may be published. However the interviewee will remain anonymous. The patient will be allowed to stop the interview at any time they wish.

Brief questions about the following:

Opening statement

I understand that you have been discharged. Did you expect to be [discharged / not to be discharged] when you came to clinic this morning? Yes/No

(EXPERIENCE of discharge)

So tell me, how do you feel about being [discharged/ not being discharge?]

Probe more

1. "Tell me what do you mean by that?"
2. Why do you feel this way?
3. "Tell me a little more about this."
4. "What was that like for you?"

(APPROPRIATENESS of discharge)

Do you think it was the appropriate for you to be [discharged/ not to be discharged?] Yes/No

Probe more

1. "Why is that so?"
2. "Can you tell me more about this?"
3. What are your concerns regarding the decision to discharge you?
4. Did the doctor address your wishes or worries appropriately?

(SHARED DECISION MAKING in discharge)

Did you feel that were involved in the process of making that decision to [discharging you or not discharging you?] Whom do you think should be involved in the process of discharging you?

(FACTORS INFLUENCING PATIENT'S EXPERIENCE regarding the discharge /not being discharge decision made by the clinician in the outpatient dermatology clinic)

Clinician related factors

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1. Are you confident that the clinician understood your case?
2. Did the doctor provide you with all the information necessary for you to self-manage prior to discharge?
3. Was the information clearly explained?
4. Would it be helpful if you had some warning about discharge in advance?
5. Probe more

1. "Why is that so?" 2. "Can you tell me more about this?"

Patient related factors

1. How much influence would your understanding of your disease influence the decision to discharge or not discharge you?
2. How much influence would your understanding of your medication influence the decision to discharge or not discharge you?
3. How would your level of ability to self-manage influence the decision to discharge or not discharge you?
4. How much influence would your wishes affect the decision to discharge or not discharge you?
5. How much influence would your type of job affect the decision to discharge or not discharge you?
6. How much influence would the distance of your home to the hospital affect the decision to discharge or not discharge you?
7. How much influence does your skin quality of life or in general affect the decision to discharge or not discharge you?
8. How much influence would the presence of a carer affect the decision to discharge or not discharge you?

Probe more

1. "Tell me more on these factors?" 2. "Can you give me an example or any experience relating to this?"

Practice related factors

1. In general, can you give me any ideas what can be done to improve the discharge process for patients?
2. In your opinion what do you think is important for the dermatologist to consider or discuss with you before discharging you, in this case?
3. Any suggestions about how the clinic administrative system should operate to improve the discharge process?

(TIMING of discharge)

Did you have any prior notice about the possibility of when you will be discharged before this? Yes/No

Thank you very much for your time. Is there anything else you would like to add?

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Appendix 3 Coding tree

+**THEME 1 Well informed, certainty of diagnosis and treatment plan**

- **+Well informed**
  - -Clinician experience
  - -Clinician's expertise
  - -Confidence
    - ^Project confidence
  - -Provide information
    - ^Information leaflets
    - ^Information concerning limits of hospital services
- **+Certainty**
  - -Diagnosis
  - -Investigation
    - ^Complete
  - -Treatment
    - ^Good response
    - ^Complete
  - -Treatment plan
    - ^Clarity in treatment plan
    - ^ Provide treatment alternatives
  - -Cure

+**THEME 2 Ascertain patients' ability to cope and self-manage**

- **+Coping with the disease**
  - -Diagnosis
    - ^Understanding diagnosis
    - ^Acceptance of diagnosis
  - -Treatment
    - ^Understanding of medication
    - ^Able to self-manage
- **+Presence of a Carer**
- **+General Practitioner (GP)**
  - -Knowledgeable
  - -Type of practice
  - -Relationship with patient

+**THEME 3 Effective patient communication and address concerns**

- **+ Effective communication**
  - -Use of simple terms to convey information
  - -Consider patient's ability to speak English
  - -Clinician's mannerisms
    - ^Show empathy
    - ^Project confidence
    - ^Unrushed and relaxed
  - -Consider whether patient is happy to be discharged
  - -Explain reasons for discharge
  - -Perceive accurately patients' needs or wishes
  - -Reassurance
  - -Shared decision making
  - -Paternalistic approach to decision making
- + **Address concerns**
  - -Emotional concerns
  - -Skin quality of life
  - -Job
  - -Distance home to clinic
  - -Family concerns

+ **THEME 4 Efficient clinic organization and clinical practice**

- + **Efficient clinic organization**
  - -Easy re-access to secondary care
    - ^Contact number of secretary
  - -Shorter waiting list for specialist care
  - -Open appointment
  - -Support from clinical staff
    - ^nurse support
- **+ Efficient clinical practice**
  - -Good Dermatologist-GP coordination and communication
  - -Notice of possible discharge
  - -Able to see same clinician for appointments prior to discharge
  - -Joint colleague discussion

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Appendix 4

Patients' Quotations

Quotation 1

"I have been going to the doctor since I was 15 and now I am 23. It has taken a long time to get to this stage, so I am very happy. It could have been a lot better if it was addressed a lot earlier. I understand that there is no cure. I understand how to deal with it. I am happy to be discharged because he explained to me clearly, and he has helped me understand my condition."

Quotation 2

"This acne has always been a problem in school and now I am discharged, it seems to me that it is the end of the treatment and my spot in skin should be cleared soon. I guess I feel more confident of myself."

Quotation 3

"They are the experts, I am not. I do not know enough, I rely totally on them."

Quotation 4

"Overall I was handled appropriately. I was asked "Are you happy to be discharged?", as long as that was asked I am happy to be discharged. If I still had active blisters and if he asked "Are you happy to be discharged?" I would have said "No". But since it has subsided a little bit I was okay with the discharge."

Quotation 5

"I just want someone to know what it is. Whenever I see anybody, nobody knows what it is. It is just looked at and I have to go."

Quotation 6

"This doctor here has got blinkers on, in other words I suppose he only sees what he wants to see. Even though the test did not come back what he thought it was, he's still got the same opinion."

Quotation 7

"Because the way the doctor kind of explained it, I sort of agreed with the doctor even though I was upset". "It seemed to me that the doctor just couldn't get me out of the room quick enough."

Quotation 8

"The doctor should have been able to prescribe the most efficient treatment for me; surely from the NHS, not to give me a private website! I pay tax all my life, I haven't come to a private dermatologist have I? I think the clinician is influenced by her perception of cost. From my point of view she was concerned about money with the NHS."

Quotation 9

"I did not expect to be discharged, at least not until the patch test was done. Patients would not expect to be discharged until all the tests are done."

Quotation 10

"Sometimes you don't realise that you are becoming unwell, therefore you need some kind of medical intervention from the hospital. I would like to have an expert to look out for these changes."

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Quotation 11

"GPs have a broader understanding but they aren't specialised enough, they wouldn't be up to date with the latest treatment. No disrespect to GPs."

Quotation 12

"Patients tend to feel intimidated by the medical profession and by the use of medical jargon. Jargon places barriers between the patient and the doctor."

Quotation 13

"If you are told that we are "finished" with you so you are discharged, that can be really upsetting to some people. It can make them feel abandoned. Doctors have to be a lot clearer what the process is going to be and what's going to happen."

Quotation 14

"Overall I was handled appropriately. I was asked "Are you happy to be discharged?", as long as that was asked I am happy to be discharged."

Quotation 15

"The doctor told me this: "We will discharge you if you are happy with that?" It would be frustrating for the doctor if I said, "No I am not happy"….what more could they do!"

Quotation 16

"If I wasn't suffering, I wouldn't be so worried! I live alone, I could not shop for myself. I couldn't get out. I went two days without food. I couldn't sleep because of the urticaria. I felt so bad. I was thinking silly things like putting a rope round my neck. These stupid things flash into your mind."

Quotation 17

"Notice of discharge is not appropriate; these clinics are busy, if you did the treatment you don't need another appointment to be told that again. If it's appropriate to be discharged why clog the clinic even more?"

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Document: Reply to Ms Fay Pearson (Assistant Editor to the BMJ Open)

Date: 5 July 2016

Editor's comments:

Before we can progress with your submission, please complete and include a COREQ check-list, ensuring that all points are included and state the page numbers where each item can be found: the check-list can be downloaded from here: http://www.equator-network.org/reporting-guidelines/coreq/

Corresponding author's reply:

- The COREQ Checklist has been completed
- All points related to the needs of the checklist have been listed and further explained in the manuscript.
- Page numbers where each item can be found have been stated in the checklist

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Table 1 Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

DOMAIN 1: RESEARCH TEAM AND REFLEXIVITY

PERSONAL CHARACTERISTICS

1. Q: **Interviewer/facilitator**: Which author/s conducted the interview or focus group?
   A: Nur Ainita Harun (First author, female researcher) conducted the interviews
   Page 5

2. Q: **Credentials**: What were the researcher's credentials? E.g. PhD, MD
   A: MBBS (Malaya), DDSc (Dermatological Sciences, Wales)
   Page 1

3. Q: **Occupation**: What was their occupation at the time of the study?
   A: Research fellow (Postgraduate PhD student)
   Page 1

4. Q: **Gender**: Was the researcher male or female?
   A: Female
   Page 5

5. Q: **Experience and training**: What experience or training did the researcher have?
   A: NAH is a clinician trained in internal medicine and dermatology. NAH received training in qualitative interviewing and transcription analysis, and conducted mock interviews before interviewing participants.
   Page 5

RELATIONSHIP WITH PARTICIPANTS

6. Q: **Relationship established**: Was a relationship established prior to study commencement?
   A: No. NAH did not know any of the participants before the study commenced.
   Page 6

7. Q: **Participant knowledge of the interviewer**: What did the participants know about the researcher e.g. personal goals, reasons for doing the research?
   A: The participants only knew that NAH was a dermatology clinician who was currently a full time researcher.
   Page 6

8. Q: **Interviewer characteristics**: What characteristics were reported about the interviewer/facilitator? Bias, assumptions, reasons and interests in the research topic
   A: NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumption was made that interviewer bias would be minimised by one person carrying out all the interviews.
   Page 5

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DOMAIN 2: STUDY DESIGN

THEORETICAL FRAMEWORK

9. Q: **Methodological orientation and Theory:** What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
   A: A thematic analysis underpinned the study: themes were derived from the data and not identified in advance.
   Page 7

PARTICIPANT SELECTION

10. Q: **Sampling**: How were participants selected? e.g. purposive, convenience, consecutive, snowball
    A: Participants were selected using a convenience and purposive sampling methods.
    Page 5

11. Q: **Method of approach:** How were participants approached? e.g. face-to-face, telephone, mail, email
    A: After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2).
    Page 7

12. Q**: Sample size:** How many participants were in the study?
    A: In the study, 64 consultations were observed and 56 patients were interviewed.
    Page 6

13. Q: **Non-participation**: How many people refused to participate or dropped out?
    A: Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.
    Page 8

SETTING

14. Q**: Setting of data collection:** Where was the data collected? e.g. home, clinic, workplace
    A: The study took place in the dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff.
    Page 5

15. Q**: Presence of non-participants:** Was anyone else present besides the participants
    A: Yes. In 17 interviews a family member of the patient was present.
    Page 10

16. Q: **Description of sample:** What are the important characteristics of the sample?

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A: The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews.
Page 5

DATA SATURATION

17. **Interview guide:** Were questions, prompts, guides provided by the authors?
A: Yes. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed.
Page 5

18. **Repeat interviews:** Were repeat interviews carried out? If yes, how many?
A: No repeat interviews were carried out and the participants did not provide feedback on the findings.
Page 7

19. **Audio/visual recording:** Did the research use audio or visual recording to collect the data?
A: Yes. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and it was audiorecorded.
Page 7

20. **Field notes:** Were field notes made during and/or after the interview or focus group?
A: Yes. Field notes were made during the interviews and reflective notes made afterwards.
Page 7

21. **Duration:** What was the duration of the interviews or focus group?
A**:** Mean interview time was 20 minutes (range 5-40 minutes).
Page 10

22. Data saturation: Was data saturation discussed?
A**:** Yes. Data saturation was achieved after 41 interviews.
Page 10

23. **Transcripts returned:** Were transcripts returned to participants for comment and/or correction?
A**:** No. Transcripts were not returned to participants for comment. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion.
Page 7

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DOMAIN 3: ANALYSIS AND FINDINGS

DATA ANALYSIS

24. **Number of data coders:** How many data coders coded the data?
    A: Three of the authors were involved in the data coding
    Page 7

25. **Description of the coding tree:** Did authors provide a description of the coding tree?
    A: Yes, a description of the coding tree is provided.
    Page: Appendix 3 in the supplementary file.

26. **Derivation of themes:** Were themes identified in advance or derived from the data?
    A: A thematic analysis underpinned the study: themes were derived from the data and not identified in advance.
    Page 7

27. **Software:** What software, if applicable, was used to manage the data?
    A: N Vivo 10 Qualitative Data Analysis Software
    Page 7

28. **Participant checking:** Did participants provide feedback on the findings?
    A: No. The participants did not provide feedback on the findings.
    Page 7

REPORTING

29. **Quotations presented**: Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number.
    A: Participant quotations are presented. Quotation numbers are used but not participant numbers.
    Page: Refer to the manuscript where the quotations are placed.

30. **Data and findings consistent**: Was there consistency between the data presented and the findings?
    A: Yes
    Page: 8-15

31. **Clarity of major themes:** Were major themes clearly presented in the findings?
    A: Yes. These are presented in the Results and the Discussion.

32. **Clarity of minor themes:** Is there a description of diverse cases or discussion of minor themes?
    A: Yes: page 12-15

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Understanding clinician influences and patient perspectives on outpatient discharge decisions: a qualitative study.

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ABSTRACT

Objective

To observe influences on clinicians when discharging outpatients, to explore patients' perspectives concerning their discharge decision and to identify what patients think clinicians should consider when taking discharge decisions.

Design

Qualitative study: observations of consultations and semi-structured interviews with outpatients.

Setting

National Health Service outpatient clinics at a university hospital secondary referral centre.

Participants

64 consultations observed, followed by 56 interviews with patients over 18 years old.

Main outcome measure

Analysis of patients' perspective and expectations concerning whether or not they were discharged.

Results

25 types of influences were observed influencing the discharge decision process. 25 types of influences were observed to be influencing the discharge decision process. All 31 discharged patients apparently accepted the clinicians' decision, however 10 (22%) later expressed disappointment. Patients' discontent was due to perceived clinicians' uncertainty in diagnosis (patients mentioning=2), poor acceptance of the diagnosis (2), disease not "cured" (4), differing perception on medical needs (2), lack of concern for job demands (1), felt uninvolved in the decision making (4), feeling rushed (3), prolonged open appointment (2), pushed to seek private care due to healthcare budget constraints (2), language barrier (1), and not keen to continue follow-up with GP (2). Patients were happy when diagnosis was certain (19), given clear treatment plan (16), advised on treatment side effects (7), given contact number if symptoms recurred (4), travelling and job demands considered (3).

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Conclusions

Accurately perceiving patients' perspectives is important in ensuring appropriateness of outpatient discharge. There was a disparity between patients' and clinicians' perception of what was an appropriate discharge. This included different perspectives concerning diagnostic certainties, private healthcare as an alternative, need for easy re-access and choice of words surrounding discharge. Medical education should include handling these issues.

STRENGTHS AND LIMITATIONS OF THIS STUDY

Strengths

- Data was derived from direct consultation observations by a single observer.
- The qualitative method used, interviewing patients immediately after discharge, encouraged patients' honesty about their experiences, when reassured that their comments would not affect further treatment.
- The usage of a topic guide during interviews focused patients specifically on the discharge decision process.

Limitations

- The study was based on only one centre and may not be a true reflection of discharged patients in general.
- The findings may have been affected by the clinic organisation or local discharge policies where it is possible that clinicians in a less busy clinic with more auxiliary support may interact with patients differently.
- The finding of inappropriateness of discharge was a largely unexpected outcome of this study and the methodology of the study had not been planned to explore this. A further qualitative study needs to be carried out, focusing on interviewing only patients who were "unhappy" or dissatisfied with their discharge, to explore this important issue further.

MANUSCRIPT

INTRODUCTION

Outpatient discharge decision-making occurs across the whole of medicine; it has a critical influence on service efficiency and patient satisfaction but very little is known about it. There are 82.1 million UK outpatient hospital visits annually.[1] At every consultation the clinician takes an implicit or explicit decision to discharge or see the patient again. Clinicians are under pressure to discharge patients to increase capacity.[2] Although strategies [3-5] have aimed at reducing secondary care demand, patients still prefer to see consultants rather than general practitioners (GPs).[6] Clinicians balance their perception of patients' needs, ethical awareness and the intricate influences surrounding discharge in order to take

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appropriate decisions.[7] Patients' attitudes towards their disease, wishes and their behaviour are also key considerations.[8,9] Clinicians therefore have to contend with complex influences, including possibly inaccurate perception of patients' expectations,[8-10] and the desire to discharge "difficult" patients [8,10,11] while continuing to review patients they know well.[8,9] There is a real risk of biased clinician decision-taking [8,12] .

Few studies[13-16] have examined what outpatients think about their discharge. Seeking to understand patients' views[17-19] may improve patients' discharge experience. Considering patients' wishes over follow-up preference may minimise unneeded appointments. Improved communication [8,9,15,17-19] and explanation of reasons behind discharge[9] may alleviate distress. Lack of planning of care around discharge[15] may result in an unhappy patient and family: incorporating patients' perspectives in the discharge process is critical.[7,8,15-19] The aims of this qualitative study were to observe what influenced clinicians before discharging patients, to explore patients' perspectives concerning their discharge or followup decision and to identify what patients think is important for clinicians to consider when taking a discharge decision.

METHODS

Participants

South-East Wales Local Research Ethics Committee gave ethical approval. The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews. NAH, first author and female researcher conducted the interviews. NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumptions were made that the interviewer biased will be minimised by one person carrying out the interviews. NAH is a clinician trained in internal medicine and dermatology. She received training in qualitative interview and transcription analysis, and conducted mock interviews before interviewing participants. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed.

Sampling

The study participants were selected using both convenience and purposive sampling methods. Selecting a "convenience" sample is the commonly used method of non-probability sampling, recruiting people who are easy to reach. Only those patients who attended the outpatient dermatology clinic sessions were selected. "Purposive" sampling, also known as "selective" or "subjective" sampling, is a type of non-probability sampling technique. As this study was about understanding how adult dermatology outpatients were discharged from the clinic, the participants were selected based on the judgement of the researcher because they were dermatology patients attending outpatient clinics with the likelihood of getting discharged. We considered the optimum sample size of interviewees, being informed by a previous study[16] where saturation of information from interviewees was achieved at the 46th face-to-face interview, and recruited an additional 15 patients to avoid bias and increase the robustness of the data.

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The recruitment process

Recruitment strategy was to include a variety of patients of different gender, ages, job and education status and a variety of skin conditions, simple, complex, medical and surgical. The researcher selected clinic sessions which had both surgical and medical patient attendances. Recruitment was aimed at patients who were likely to be discharged. Before each clinic session, the consultant reviewed the patient appointment list and case notes and informed the researcher of patients who were "potential" candidates for the study. The researcher would agree or disagree with the consultants' suggestion based on the demographic characteristics of patients whom she had interviewed earlier, in an attempt to recruit patients with a wide range of demographic characteristics and diseases. The cooperation of the consultant was critical because of his/her background knowledge of patients' problems, circumstances, and disease severity.

When a patient was called in to the consultation room, the consultant sought verbal consent for the consultation to be observed. The researcher was then introduced to the patient and the patient's agreement reconfirmed. Following the consultation, the consultant would again check the patient's agreement and the researcher then interviewed the patient in a separate room. After each interview the researcher would wait for the consultant to call her in for the next patient. It was difficult to keep a good balance of surgical and medical cases because most of the patients who refused to be interviewed were those with complex, medical skin conditions. NAH did not know any of the participants before the study commenced. The participants only knew that NAH was a dermatology clinician who is currently a full time researcher.

Data collection and analysis

In the study, 64 consultations were observed and 56 patients were interviewed.

Consultation observations

The observations of patients' discharge during the consultations with consultants were used as part of a mixed methods research strategy to compliment the subsequent patient interviews. This study approach has the potential to confirm or contrast findings within a wider study. The researcher's status as a nonparticipant observer was made clear to consultants and participants. Extracting what influences the consultants' discharge decision taking process can be difficult because the observer can only make assumptions concerning these influences. In order to make note-taking of observations of consultations more structured, a "Consultation Observation Checklist" was used (see Appendix 1) to record observations of how clinicians took discharge decisions. The checklist was developed based on discharge influences identified in the literature review and from previous clinicians' interviews.[8-10] It was impossible to collect everything during the observation process, therefore it was necessary to gain early insight into what interactions take place during the decision process.[20] The question, "How was the consultant's demeanour?" within the "Consultation Observation Checklist" was designed to address whether, and if so how, the intents and ethos described by the consultants were enacted in practice. For example, as some consultants in a previous study[7] had stated that they displayed empathy when informing patients of their discharge, we used the observational approach to observe whether this was reflected in

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practice. The researcher observed the participants' speech, facial expressions and gestures used[21] during their discussions with patients. The researcher also noted whether the consultants tried to make sure that patients understood their diagnosis and how to self-manage before discharging them. The observation method was used to understand consultant behaviour within a naturalistic context, complementing, verifying and validating data extracted from participant interviews.[21]

During the observation of consultations the researcher made multiple notes recording the consultants' demeanour. In addition the researcher observed the type of factors influencing the consultants' discharge decision taking and recorded each influence using the "Consultation Observation Checklist".

The checklist data was analysed by counting the number of checklist influences recorded during each consultation and also by counting the number of consultations in which each influence occurred. These data were converted to percentages to make the comparison clearer. The checklist was piloted in eight consultation observations and altered based on that experience. New influences not in the "Consultant Observation Checklist" were added.

The structured recording of data assisted the subsequent manual analysis of how frequently these influences occurred with each consultant and in relation to the context of the decision being made. After each observation, the researcher looked through each influential factor and related it to the discharge or follow-up decision. The checklist helped us to identify patterns of what clinicians considered most before discharging patients and to understand how different patients were handled. For instance by observing the clinicians' demeanour made it possible to compare how clinicians reacted to different patients during the discharge decision making process. The consultant's demeanour, the patient's verbal and nonverbal responses such as facial expressions were correlated with the list of influential factors. These observations were also interlinked with the clinic ambience and circumstances which occurred during the whole discharge decision making process. For example, one consultant asked an elderly patient whether she could apply the cream at home and be discharged, but the patient insisted on a follow-up because of the lack of assistance since she was living on her own. Each consultation was analysed using this method. Outcomes which were similar were categorised under the same heading (influential factor). One of the limitations of this data analysis was that categorical data handling may result in a conceptual grid and there may be new categories or influences missed. However, this limitation was addressed by the pilot observation study.

Patient interviews

Immediately after the consultation patients were invited for interview. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and it was audiorecorded. At the interview end, a question such as "is there anything more you would like to add?" was asked to encourage further patient ideas. We planned interviewing at least 10 more patients after reaching saturation. No repeat interviews were carried out and the participants did not provide feedback on the findings. It would have been ideal for the researcher to interview each consultant immediately after the observation session to confirm whether each factor really had an influence on discharge decision-making process. However, the prime focus of this study was to gain the patients' insights.

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Coding themes and subthemes of the data set

Field notes were made during the interviews and reflective notes afterwards. Transcripts were not returned to participants for comment. Three of the authors were involved in the data coding (Figure 1). Interviews were transcribed and manually analysed by coding data in the printed transcript margin.

In this study a thematic analysis, a method for identifying, analysing and reporting patterns within data,[22] was conducted which involved searching repeated patterns (themes) across all data sets. A theme captures something significant or meaningful about the data set in relation to the overall research question and is not necessarily dependent on how little or often such a theme appears throughout the data set. The researcher's judgement is critical to decide what a theme is. The researcher (NAH) transcribed the interviews and reviewed the data, generated initial codes in a structured fashion and collated the codes into potential themes. These themes were then checked to confirm whether they related well to the coded extracts within the entire data set and finally each theme was clearly defined and named. [22]

Duplications were removed and similar categories grouped and reduced into broader sub-themes. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion. Analysis focused on the patients' perception of discharge appropriateness, patients' discharge expectations and what they thought clinicians should consider before discharging them. Transcripts were further analysed using NVivo 10, Qualitative Data Analysis Software to aid data organisation.

Statistical analysis

A "descriptive statistical analysis" of the data is reported. This consists of reporting percentages of items observed.

RESULTS

Participants (Consultants)

A total of 64 observations of dermatology consultations and 56 face-to-face patient interviews were conducted and analysed in a dermatology outpatient clinic. Table 1 describes the characteristics of the dermatology consultants who took part in the study. All but one consultant agreed to participate.

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Table 1. Demographic characteristics of the consultant dermatologists (N=7)

Consultant Dermatologists	**Number (N)**
Male	5
Female	2
Mean age (range)	50.8 years (38-56)
Indigenous British	4
Ethnic minority	3
Type of NHS Contract	
Full time	7
Part time	0
Also working in private practice	3
Years of clinical experience in dermatology	
30-40 years	2
20-29 years	3
10-19 years	1
< 10 years	1
Main special interest in dermatology	
Medical	4
Surgical	2
Paediatric	1

Consultant Observations

Table 2 describes the number of consultations, out of the total 56, in which each "Consultation Observation Checklist" influence was observed.

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Table 2. Number of consultations in which each "Consultation Observation Checklist" influence was observed (56 consultations observed)

	N= Number of consultations in which the influences were observed	Percentage (%)
DISEASED BASED INFLUENCE		
Type of diagnosis	56	100
Certainty of the diagnosis	39	70
Disease progression	26	46
Comorbidities	15	27
Type of treatment	41	73
Response of treatment	38	68
Completion of treatment	20	36
Treatment side effects	12	21
Disease monitoring	28	50
Usage of dermatology treatment guidelines	5	9
PATIENT BASED INFLUENCE		
Age	3	5
Gender	0	0
Culture	0	0
Communication (language barrier)	2	4
Mobility	0	0
Distance	5	9
Circumstances surrounding patient's life	0	0
Carer or family member to assist at home	19	34
Cognitive ability	0	0
Learning difficulties	0	0
Psychological concerns	2	4
Patient's quality of life	4	7
Understanding of the disease	0	0
Patient's acceptance of disease	28	50
Patient's ability to self-manage treatment	36	64
Patient's compliance with medication	0	0
Patients' initiative to engage with support groups	0	0
Patient's concerns about job	3	5
Patient's expresses wish to be discharged	2	4
PRACTICE BASED INFLUENCE		
Academic interest	5	9
Reassure patient easy reaccess to secondary care	27	48
Joint colleague discussion	7	13
Nurse assisted in explaining treatment	3	5
Ascertain patient-GP relationship	2	4
Ascertain GP's skills in handling dermatology cases	2	4
Ascertain GP's willingness to share care	0	0
Ascertain availability of treatment in secondary care	16	29

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Discharge due to wrong referral	0	0

25 types of influences were observed to be influencing the discharge decision process. Table 3 presents the relationship of observed influential factors to the likelihood of discharge or followup, based on the "Consultant Observation Checklist" and other recorded observations.

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Table 3. Relationship of observed influential factors to likelihood of discharge or followup

*GP= General Practitioner

Observed influential factors (N=25)	**Patient is likely to be discharged if the influence aspect (column 1) is as follows:**	**Patient is likely to be followed up if the influence aspect (column 1) is as follows:**
Type of diagnosis	Disease is self-limiting or simple	Disease is severe or complex
Certainty of the diagnosis	Diagnosis is confirmed	Biopsy is needed to confirm diagnosis
Patient's acceptance of the diagnosis	Understands and able to accept diagnosis	Doubtful about diagnosis accuracy
Type of referral	Wrong referral	Appropriate referral
Joint colleague discussion to confirm diagnosis	Clinician is confident of diagnosis	Clinician is unsure of diagnosis, needing joint colleague discussion to confirm diagnosis
Comorbidities	Patient with no other problems	Patient with multiple diagnoses
Guidelines	Treatment which does not involve guidelines	Treatment which involves guidelines (such as for melanoma)
Disease progression	Stable or asymptomatic	Recurrent
Disease monitoring	Treatment plan which can be monitored by GP	Treatment plan which needs hospital monitoring
Type of treatment	Topical treatment with minimal side effects	Ongoing systemic medication or biologics
Completion of treatment or "cured"	Tumour fully resected	Multiple tumours and recurrent tumours
Treatment response	Good treatment response	Poor treatment response
Treatment availability	Not available or treatment not possible in the NHS	Many treatment options available in the NHS
Patient age	Younger patients	Older and frail patients
Patient attitude	Patients who appears confident	Patients who have a long term relationship with consultant
Carer	Presence of carer or family	Living alone
Communication	Ability to communicate well	Language barrier
Job	Busy	Retired
Distance	Lives away and travelling difficulties	Easily mobile, independent
Psychosocial concerns	None	Present, and lack of resources to

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		handle concerns
Skin disease burden	Coping well	Not coping well.
Self-manage	Understood well and agreed to self-monitor disease	Difficulties in coping or lack of support to monitor disease
GP relationship	Good relationship with GP	Doubtful of GP's expertise
GP's skills	Skillful GP or GP with dermatosurgical facilities	Perceived inadequate GP dermatology skills
Wishes or concerns	Patient accepts advice after addressing wishes or concern	Unrealistic expectations or too many concerns making it impossible to handle in one clinic setting

During the observation of consultations, the gender, ethnicity and years of experience of consultants were not perceived to relate to patients' satisfaction or dissatisfaction concerning the decision whether or not to discharge them. However one patient with a different ethnic background to the consultant had difficulty understanding the disease management plan and the patient was not discharged. Consultants who worked in private practice appeared to be more confident in providing information to patients if the skin condition was not treatable under the NHS.

Pattern of discharge of practice

The pattern of discharge practice differed depending on various influences. Consultants had their own personal demeanour and unique method when handling discharge: all maintained good eye contact and expressed concern. Twenty-six (46%) consultations were interrupted by colleagues or by phone calls. Consultants kept within the standard consultation time when the problem was simple. However, six consultants spent longer with patients who had special concerns about their skin. Before discharging a patient referred for a diagnosis (after many years of uncertainty), the consultant took time to explain the diagnosis, treatment possibilities and that cure was unlikely. When interviewed the patient said she was less anxious, relieved to have a confirmed diagnosis and was happy to be discharged (Quotation 1). The possible implications to this finding require further thought and development of strategies to improve clinic discharge management by reducing disruption of clinic consultations. As part of a wider study[8] 40 consultants were asked about the strategies that could be used to improve discharge decision taking: one of these was to train juniors in effective time management. All consultants clearly explained the diagnosis to patients: in two instances the diagnosis was ambiguous but the patient was discharged after reassurance. Patients accepted their discharge readily after a good surgical outcome. An elderly patient appeared relieved when not discharged: she stated that despite normal clinical findings, she was followed up because the consultant had cared for her for years and understood her well. If treatment was complex and needed primary care blood monitoring, consultants tended to check on the patient's motivation to self-monitor. When discharging, one consultant always concluded by asking "Is there anything else I can help you with right now?"

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Participants (Patients)

Fifty-six patients with medical, surgical, subacute and chronic skin conditions were interviewed (26 (46%) male, mean age 54 years, range 18 - 80). Table 4 presents the demographic characteristics of the patients. Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.

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Table 4. Demographic characteristics of the patients who were interviewed and whether they were discharged or not

Study Participants	Number	Percentage (%)	Discharged	Not discharged
Male	26	46		
Female	30	54		
Mean age (range)	53.9 years (18-80)			
Indigenous British	50	89		
Ethnic minority	6	11		
Education level				
Primary	1	2		
Secondary	31	55		
Tertiary	24	43		
Type of skin disease				
Medical	29	52		
Surgical	24	43		
Unconfirmed diagnosis	3	5		
Type of job				
Employed	19	34		
Self-employed	4	7		
Retired	28	50		
University student	3	5		
Unemployed on benefits	2	4		
Diagnosis				
Non-melanoma skin cancer	7	13%	3	4
Melanoma	1	2%		1
Eczema	5	9%	1	4
Psoriasis	3	5%		3
Itchy rash	1	2%	1	
Acne vulgaris	3	5%	2	1
Post inflammatory hyperpigmentation	2	4%	1	1
Actinic keratosis	4	7%	3	1

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Table 4 (continued)

Study Participants	Number	Percentage (%)	Discharged	Not discharged
Allergic contact dermatitis to latex	1	2%	1	
Benign mole	2	4%	2	
Ingrown hair	1	2%	1	
Melasma	2	4%	1	1
Skin cancer and renal transplant	1	2%		1
Urticaria	2	4%	2	
Dermatofibroma	2	4%	1	1
Leg ulcer	1	2%		1
Onychomycosis	1	2%	1	
Nodular prurigo	1	2%		1
Lichen planus	1	2%	1	
Seborrheic dermatitis	1	2%	1	
Polymorphic light eruption	4	7%	3	1
Photosensitive dermatitis, photoaggrevated rosacea and UVA sensitivity	3	5%	1	2
Insect bites	2	4%	1	1
Rosacea	2	4%	2	
Uncertain diagnosis	3	5%	2	1
Total	56	100%	31	25

Patient interviews

Data saturation was achieved after 41 interviews: 15 more confirmed saturation. Mean interview time was 20 minutes (range 5-40 minutes). NAH undertook all observations and interviews. Patient quotations are given in Appendix 3. In 17 interviews a family member of the patient was present. “Discharged due to a wrong referral”, identified in the pilot study was added to the template. All 31 discharged patients appeared to agree with the clinician’s decision to discharge them. However, when interviewed, 12 had not expected discharge. Two of these were happy: one was given the reassurance of easy clinic re-access and the other was relieved the treatment had finished (Quotation 2). The other 10 patients were unhappy, critical of the clinicians’ attitude and incorrect perception of their needs. Eight had chronic disorders and had been followed-up long-term. Only two were at their first appointment. Three patients who had expected to be discharged were given a follow-up: one felt that there were limitations to the consultant’s expertise, one perceived that no lesions were recurring and one felt nothing more could be done. The analysis of patient interviews resulted in 14 main categories which were classified into three main themes:

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(I) Patient attitudes to discharge: 1) patient expectations, 2)patients' feelings and 3) patients' participation in decision making; (II) Factors which needed to be considered when taking discharge decisions: (1) clinicians must be certain of their diagnosis and treatment plan and ascertain that patients are well informed; (2) ascertain patients' ability to cope and self-manage after discharge; (3) effectively communicate with patients and address their concerns; (4) organise and manage the outpatient clinics efficiently; (III) Factors which contributed to an inappropriate discharge: 1) uncertainty of diagnosis, 2) none-acceptance of the final diagnosis, 3) discharge without "curing" the patient, 4) differing perceptions on medical need and "cosmetic" demand, 5) lack of concern for job demands, 6) projecting a "rushed" demeanour and 7) advised to seek private care because of budget constraints.

Coding themes and subthemes of the data set

Details of the coding themes and subthemes are presented in Figure 1.

Patients' attitudes to discharge

Patients' expectations

One patient with acne had not expected discharge despite significant improvement. He assumed he would not be discharged until completion of treatment. But another similar patient was relieved to be discharged, inferring that his disease was controlled.

Patients' feelings

An elderly patient, who experienced slight nerve damage secondary to excision of a skin cancer, agreed to discharge without any concern. However, a university student was dismayed by the decision to discharge, although his facial seborrhoeic dermatitis was clearly improving with medication.

Patients' preference for decision making

Retired patients were less likely to engage in the discharge discussion. They accepted a more paternalistic approach and were less likely to negotiate follow-up (Quotation 3). When interviewed, only two of the retired patients (7%) preferred to have a discussion over whether or not to be discharged. Patients in employment and young adults apparently felt strongly that they should be involved in the discharge decision and two stated they would inform their consultant if they did not agree with the decision (Quotation 4). Patients who had chronic or complex problems were keen to be involved in the decision-making and preferred to be notified in advance about the possibility of discharge. Patients with surgical disorders were less demanding, saying they were impressed with the department's services. However, two patients stressed that they should not have been discharged without the dermatology surgeon (preferably) inspecting the surgical wound.

Four key considerations when taking discharge decisions

Well informed, certain diagnosis and treatment plan

Patients expected clinicians to be certain of their diagnosis (n=39) and provide a clear treatment plan (n=38). All stressed that providing clear information about their disease, patient information leaflets and

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website addresses is essential before discharge, empowering self-management and enhancing their confidence. Most patients with chronic diseases felt "safer" to be followed up, in case treatment needed changing. Fifty-one patients expected their management to be complete before discharge, including full investigation, exploring treatments and their responses and a final thorough examination (Quotation 9).

Ascertain patients' ability to cope and self-manage

Patients are reluctant to be discharged if they feel unable to detect subtle changes heralding worsening (Quotation 10). Three psoriasis patients insisted that their disease chronicity meant they should never be discharged, even if well controlled, for fear of coping by themselves or missing new treatments. They felt more reassured being followed up by a dermatologist, even annually, than by their GP (Quotation 11): GPs need to have appropriate knowledge and to know when to re-refer.

Effective patient communication and address concerns

Patients preferred phrases such as: "I don't need to see you again" or "You can now be taken care of by your GP" to the blunter "You are discharged". Fifteen patients said that clinicians should use simple terms when providing information. However during the observations, no clinicians used medical jargon. One (doctor) patient highlighted that clinicians should be reminded not to use medical jargon with a patient, to prevent them being confused (Quotation 12). Eight patients said that, when discharging, it is important that the physician has a confident demeanour to reassure the patient. Three patients mentioned that if a patient does not speak English, an interpreter must be used. During observation, apparently all except two discharged patients understood the diagnosis. One patient noticed the clinician was unimpressed by his spots until told they were itchy, illustrating patients' sensitivity to doctors' mannerisms and body language (Quotation 13). Two patients felt it important that clinicians ask whether patients are happy to be discharged (Quotation 14). However, one patient thought this a redundant question because he did not think anything would have been done if he replied he was unhappy (Quotation 15).

Efficient clinic organization and clinical practice

Seven patients were more likely to accept discharge if assured of quick re-access to specialist care if necessary. Twenty patients felt the long waiting time for first appointments or re-referrals was daunting. One patient with severe chronic urticaria said he almost committed suicide because of intolerable pain and itch and the long delays in dermatology referral (Quotation 16). Patients were happy if they perceived good communication existed between dermatologists and GPs or other specialty consultants involved in their care. Those with comorbidities were most appreciative of the reassurance that after discharge they would still be in good hands. Five patients mentioned the importance of coordination between GP and specialist. Two patients stated that discharge was more acceptable when notice of possible discharge is given during a previous consultation or when, after biopsy, the consultant wrote to the GP confirming a benign diagnosis. However, a (nurse) patient thought otherwise (Quotation 17). Patients with chronic conditions felt that warning of discharge would allow their mental preparation. Two surgical patients were keen to see the clinician who operated on them before discharge, to give them reassurance of the surgery's success and a sense of completeness.

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Factors contributing to an inappropriate discharge

The results contributing to "Factors contributing to inappropriate discharge" were not extracted only from the ten "unhappy" patients but also from other patients who took were interviewed in the study.

Uncertainty of diagnosis

Patients insisted that clinicians should confirm their diagnosis before discharge. One patient was unhappy because she felt the clinician was uncertain of the diagnosis. She was asymptomatic because the lesions had resolved while waiting for her appointment. She mentioned at the interview that she would have preferred an open appointment for easy access should the symptoms recur rather than a fixed follow-up. However, she did not say this to the clinician. Another patient referred for diagnosis was appropriately given a follow-up. She felt that patients with rare diseases should never be discharged before making a definite diagnosis (Quotation 5).

None-acceptance of the final diagnosis

Two patients stressed that patients' acceptance of their diagnosis is important before discharge. One patient was unhappy because he did not agree with the clinician's diagnosis and expected further investigations and monitoring. He was discharged because the clinician was confident of the diagnosis and explained there was no other treatment. The patient felt that the clinician was only interested in his perception of the diagnosis and was unwilling to probe further (Quotation 6).

Discharge without "curing" the patient

One patient felt that patients with conditions with no cure should never be discharged, because of possible future advances. One student with seborrhoeic dermatitis insisted that his problem must be "cured" despite knowing this condition may recur.

Differing perceptions on medical need and "cosmetic" demand

A patient with melasma was upset because he thought the clinician perceived his problem as purely cosmetic. A young female with acne highlighted that clinicians should provide further suggestions for dealing with disease or treatment complications, such as scarring.

Lack of concern for job demands

One patient stated it was a hassle for her to be discharged and re-referred for surgical intervention if she later wanted this. She expected the clinician to understand her job demands and felt she should have been given more time to make a decision during the consultation. She said she was unable to express her disagreement due to her poor English and had felt uninvolved in the decision-making.

Projecting a "rushed" demeanour

Three patients felt upset because their clinicians appeared rushed. The patients perceived that the clinician wanted to "wrap up" the consultation and discharge them to save time. These patients were still uncertain of their diagnosis or had psychological problems. One patient said he did not express dissatisfaction because of how the clinician spoke (Quotation 7).

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Advised to seek private care because of budget constraints

Five patients were unhappy that their clinicians suggested they seek referral to a private dermatologist: actually the clinicians were informing patients about treatment only available in the private sector. Two patients did not understand NHS service limitations and felt the doctor was "following the rules" rather than prioritising the patient's best interests (Quotation 8).

DISCUSSION

In this study the mean age of patients was 54 years. 55% of dermatology outpatients range from age 45-100 years old.[23] Forty-three percent of the patients interviewed reported having had tertiary education. This is a higher level than the general population. This may be partially explained by the recruitment hospital being based in a large city centre where residents are generally well educated.

Accurate perception and certainty of information

This study has revealed that although most outpatients appeared pleased with the clinicians' discharge decisions, there may be major discordance between what clinicians thought was an appropriate discharge and patients' actual views,[13] similar to other misunderstandings between patients and clinicians.[24] Although clinicians endeavoured to address patients' needs, expressed concern and confidently arranged discharge, they mainly focused on medical[25] and were unaware of some patients' discontent over the discharge itself. Moreover, no patients objected to their discharge. Clinicians may be unwittingly biased because of overconfidence,[8,26] or previous individual experiences.[27] Skilled expertise [28] is central to accurate clinical judgement, however a standardised tool might in some instances be helpful to prevent bias.[8] For example the impact of pruritus on life quality is often underestimated[29] and patients can be inappropriately discharged. The use of a quality-of-life questionnaire may reveal how patients are coping with their problem[30] and inform the discharge decision. Although the use of a quality-of-life questionnaire may be useful to measure patients' quality of life and to highlight particular issues of importance to patients, consultants should always have a keen eye on patient's subjective experience of their disease and its treatment, including the impact on the patient of having to wait for appointments for a re-referral or how their skin problem and its management could affect their work.

Inpatients are sensitive to subtle nuances of clinicians appearing courteous but not truly curious about patients' expectations and needs.[25] This study identified that outpatients also perceive these nuances, despite short consultations. Clinicians rather focus on the basics of clinical medicine, such as diagnosing and monitoring treatment response. As problematic in the inpatient setting,[15] outpatient clinics are usually very busy and clinicians have little time to make decisions over discharge. Longer consultation times for patients' final visits would allow more detailed addressing of patients' concerns and possibly reduce biased judgements.

Patients expect continuity of outpatient care until the diagnosis is certain, but this may not always be possible. Clinicians should provide relevant information and supply information[8,9] to increase patients' confidence in the discharge process. Jointly discussing a patient's treatment plan and encouraging further questions,[31] even if a patient seems to accept discharge, could uncover unmet needs.

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Effective communication and patient engagement

Effective clinician-patient communication is a core attribute of high quality discharge-making.[9,15] Medical jargon should be avoided and an atmosphere created to encourage patients to ask questions.[13] Healthcare professionals should engage patients with chronic conditions as part of the healthcare team and in the discharge decision process. Clinicians should be mindful of their demeanour with patients. Patients emphasised the importance of clinicians projecting confidence, respecting patients' views, using "kinder" words at discharge and displaying empathy. Most dermatology patients left the discharge decision entirely to clinicians. Patient involvement should take place,[32] even if disagreeing with the final decision. Clinicians should gauge what matters most to a patient[33] before making a decision. Clinicians may miss subtle hints of patients' needs if they discount patients' personal accounts,[25] dominate a subservient patient or ignore patient involvement in the decision process.[15,34] Conflicting views on the final decision should alert clinicians to try to understand the reasons for disagreement and accept them as potentially valuable in enhancing their clinical judgement.

Addressing concerns and patient reassurance

Ideally patients' concerns should be fully addressed before discharge, but in reality this may be impossible. Some patients felt "short-changed" at not receiving the "best" treatment for conditions with a strong cosmetic element. Aggressive discharge policies or tumour management guidelines may be challenged if patients express uneasiness at not being given a follow-up after surgery. Patient dissatisfaction might be reduced if clinicians ensured that patients understood the reasons behind hospital policies. Easy access to policy documents might enable this, if written in simple language. Dermatology patients are especially vulnerable to public comments of their appearance, because skin is integral to body image and self-respect. Although treatment was often not ideal, many patients interviewed preferred to be indefinitely under the dermatology care. Difficulties arise because of a mis-match between clinicians thinking they have "reassured" a patient and the patient's actual perception.[35]

Long re-referral waiting times add worry to patients already having difficulty coping. Clinicians should be mindful of this and make provision for open return appointments or direct access if needed. If patients are discharged with severe or chronic inflammatory skin disease that needs continued monitoring, a well-coordinated management plan between the specialist and the GP [9,15] must be organised and clearly explained to the patient. Prior notification of discharge may help alleviate anxiety and give reassurance. Patients need reassurance that they will receive quality care after discharge from outpatients.[35] Although some patients favour indefinite secondary care, they should be informed of the framework of care provided by GPs [9] and their suitability for follow up in primary care: clinicians should identify patients who need primary care input or emotional support after discharge.

This study has some limitations. For example it is possible that some of the personal characteristics of the consultants, such as age, gender or ethnicity, may have been relevant to the patients' perceptions or acceptance of the discharge decisions. Our study was not designed to address this question, but no patients commented on these personal characteristics of the consultants.

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IMPLICATIONS AND FUTURE RESEARCH

The degree to which patients accept discharge varies widely: each patient's level of concern arises from their individual belief system or expectations. Patient engagement in the discharge process could contribute to the appropriateness of discharge decisions. Up to now, the patients' voice in the discharge decision has largely been ignored. However there is increasing motivation to ensure that clinical decisions are efficient and appropriate, to enhance care and for reporting performance. When taking the decision to discharge, clinicians using empathetic body language may help alleviate patients' anxiety. The clinical challenges require an appropriate mixture of coaxing and empathy along with the assessment of treatment response and consideration of the diagnosis. We need to train clinicians to think and decide about discharge systematically: clinicians should consider the patient's overall health, the clarity of the treatment plan, the patient's ability to apply treatment and to cope with treatment side effects. The wide range of issues identified by patients as important provides evidence to support targeted clinical training.

CONCLUSION

This study highlights the importance of accurately perceiving patients' perspectives in ensuring the appropriateness of outpatient discharge. This study provides a warning to clinicians that discharging a patient is even more complicated than it seems, and has opened a Pandora's Box of patients' attitudes surrounding discharge decisions. It highlights the importance of considering patients' perspectives in ensuring the appropriateness of outpatient discharge**.** Clinicians should try to include patients in discharge decisions and understand and address their wishes, especially with dermatology patients whose confidence relates to their body image. There is a need for a systematic approach to develop a science of discharge. We need first to ascertain which information is critical to consider prior to discharge and second, to understand how clinicians can gain an accurate perception of patients' expectations and avoid bias. Conflicting views relating to discharge will continue between some clinicians and patients unless clinicians more fully understand patients' expectations and are able to handle their concerns. Perhaps after beginning to hear the patient's voice surrounding discharge, clinicians should be encouraged to develop the skills needed to take consistently high quality and appropriate discharge decisions.

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Guarantor: Cardiff University

Ethics approval:

South East Wales RECs Committee-Committee C

REC: 11/WSE03/4 Date approved: 24th February 2011

The participants gave informed consent before taking part in the study.

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Data sharing statement: No additional data available.

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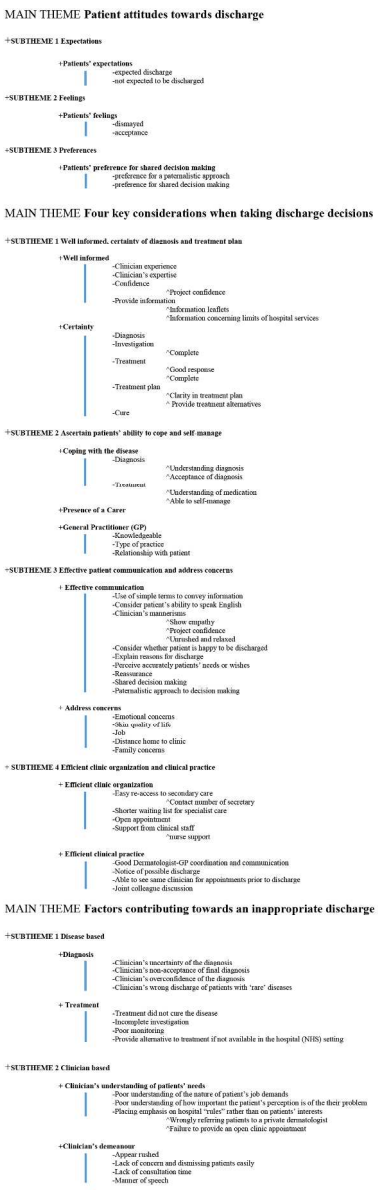

Figure 1. Details of the coding main themes and subthemes

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SUPPLEMENTARY FILE: APPENDICES

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APPENDIX 1

Consultation Observation Checklist

Factors Influencing Discharge Decisions in Outpatient Dermatology

Observation of Dermatology Consultations

Observer: Non participant

Date	
Patient Demographics	
Age	
First visit or follow up	
Discharged or follow up	
Length of consultation	
Diagnosis	
Medical	
Surgical	
Sex	
Ethnicity	
Education level	
Employment Status	
Factors which influence clinicians'' discharge decisions	N= Number of consultations in which the influences were observed
DISEASED BASED INFLUENCE	
Type of diagnosis	
Certainty of the diagnosis	
Severity of the disease	
Disease progression	
Comorbidities	
Type of treatment	
Response of treatment	
Completion of treatment	
Treatment side effects	
Disease monitoring	
Usage of dermatology treatment guidelines	
PATIENT BASED INFLUENCE	
Age	
Gender	
Culture	
Language barrier	
Mobility	
Distance	
Circumstances surrounding patient's life	
Carer	

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Cognitive ability	
Learning difficulties	
Psychological concerns	
Patient's quality of life (how was it assessed?)	
Understanding of the disease	
Patient's acceptance of disease	
Patient's ability self-manage treatment	
Patient's compliance to medication	
Patients' initiative to engage with support with groups	
Patient's concerns	
Patient's wishes	
PRACTICE BASED INFLUENCE	
Academic interest	
Reassure patient easy reaccess to secondary care	
Joint colleague discussion	
Nurse assisted in explaining treatment	
Ascertain patient-GP relationship	
Ascertain GP's skills in handling dermatology cases	
Ascertain GP's willingness to share care	
Ascertaining availability of treatment in secondary care	
Discharge due to wrong referral	

Reflection box

How was the consultant's demeanour? _____

Did the clinician show information leaflets? _____

Was there medical jargon when explaining to the patient? _____

Did the clinician notify the patient of a possible discharge in the next visit? _____

Further comments: _____

Note:

Definition of some terms used

"Understanding and acceptance of diagnosis by the patient".

This was assumed by the observer noting that patients nodded and smiled and told the consultants that they understood and accepted the diagnosis when asked by some of the consultants.

"Acceptance of disease by the patient". This was assumed by the observer if the patient nodded in agreement and agreed with the diagnosis told by the consultant.

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"Understanding of disease by the patient". This was assumed by the observer if the patients nodded, smiled and said "yes" when asked whether they understood what the diagnosis was and how to take or apply medication.

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APPENDIX 2

Patient Interview Guide

Factors Influencing Discharge Decisions in Outpatient Dermatology

Introduction

The research student will introduce herself and thank the patient for considering on being part of the study. She will give a copy of the patient information sheet to the participant to read and she will also go through any queries pertaining to their participation in the study. If the patient agrees to be interviewed, then the patient will have to sign a consent form. Both the patient and the carer will be informed that the interview will be audio recorded and some statements may be published. However the interviewee will remain anonymous. The patient will be allowed to stop the interview at any time they wish.

Brief questions about the following:

Opening statement

I understand that you have been discharged. Did you expect to be [discharged / not to be discharged] when you came to clinic this morning? Yes/No

(EXPERIENCE of discharge)

So tell me, how do you feel about being [discharged/ not being discharge?]

Probe more

1. "Tell me what do you mean by that?"
2. Why do you feel this way?
3. "Tell me a little more about this."
4. "What was that like for you?"

(APPROPRIATENESS of discharge)

Do you think it was the appropriate for you to be [discharged/ not to be discharged?] Yes/No

Probe more

1. "Why is that so?"
2. "Can you tell me more about this?"
3. What are your concerns regarding the decision to discharge you?
4. Did the doctor address your wishes or worries appropriately?

(SHARED DECISION MAKING in discharge)

Did you feel that were involved in the process of making that decision to [discharging you or not discharging you?] Whom do you think should be involved in the process of discharging you?

(FACTORS INFLUENCING PATIENT'S EXPERIENCE regarding the discharge /not being discharge decision made by the clinician in the outpatient dermatology clinic)

Clinician related factors

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1. Are you confident that the clinician understood your case?
2. Did the doctor provide you with all the information necessary for you to self-manage prior to discharge?
3. Was the information clearly explained?
4. Would it be helpful if you had some warning about discharge in advance?
5. Probe more

> 1. "Why is that so?"
> 2. "Can you tell me more about this?"

Patient related factors

1. How much influence would your understanding of your disease influence the decision to discharge or not discharge you?
2. How much influence would your understanding of your medication influence the decision to discharge or not discharge you?
3. How would your level of ability to self-manage influence the decision to discharge or not discharge you?
4. How much influence would your wishes affect the decision to discharge or not discharge you?
5. How much influence would your type of job affect the decision to discharge or not discharge you?
6. How much influence would the distance of your home to the hospital affect the decision to discharge or not discharge you?
7. How much influence does your skin quality of life or in general affect the decision to discharge or not discharge you?
8. How much influence would the presence of a carer affect the decision to discharge or not discharge you?

Probe more

> 1. "Tell me more on these factors?"
> 2. "Can you give me an example or any experience relating to this?"

Practice related factors

1. In general, can you give me any ideas what can be done to improve the discharge process for patients?
2. In your opinion what do you think is important for the dermatologist to consider or discuss with you before discharging you, in this case?
3. Any suggestions about how the clinic administrative system should operate to improve the discharge process?

(TIMING of discharge)

Did you have any prior notice about the possibility of when you will be discharged before this? Yes/No

Thank you very much for your time. Is there anything else you would like to add?

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APPENDIX 3

Patients' Quotations

Quotation 1

"I have been going to the doctor since I was 15 and now I am 23. It has taken a long time to get to this stage, so I am very happy. It could have been a lot better if it was addressed a lot earlier. I understand that there is no cure. I understand how to deal with it. I am happy to be discharged because he explained to me clearly, and he has helped me understand my condition."

Quotation 2

"This acne has always been a problem in school and now I am discharged, it seems to me that it is the end of the treatment and my spot in skin should be cleared soon. I guess I feel more confident of myself."

Quotation 3

"They are the experts, I am not. I do not know enough, I rely totally on them."

Quotation 4

"Overall I was handled appropriately. I was asked "Are you happy to be discharged?", as long as that was asked I am happy to be discharged. If I still had active blisters and if he asked "Are you happy to be discharged?" I would have said "No". But since it has subsided a little bit I was okay with the discharge."

Quotation 5

"I just want someone to know what it is. Whenever I see anybody, nobody knows what it is. It is just looked at and I have to go."

Quotation 6

"This doctor here has got blinkers on, in other words I suppose he only sees what he wants to see. Even though the test did not come back what he thought it was, he's still got the same opinion."

Quotation 7

"Because the way the doctor kind of explained it, I sort of agreed with the doctor even though I was upset". "It seemed to me that the doctor just couldn't get me out of the room quick enough."

Quotation 8

"The doctor should have been able to prescribe the most efficient treatment for me; surely from the NHS, not to give me a private website! I pay tax all my life, I haven't come to a private dermatologist have I? I think the clinician is influenced by her perception of cost. From my point of view she was concerned about money with the NHS."

Quotation 9

"I did not expect to be discharged, at least not until the patch test was done. Patients would not expect to be discharged until all the tests are done."

Quotation 10

"Sometimes you don't realise that you are becoming unwell, therefore you need some kind of medical intervention from the hospital. I would like to have an expert to look out for these changes."

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Quotation 11

"GPs have a broader understanding but they aren't specialised enough, they wouldn't be up to date with the latest treatment. No disrespect to GPs."

Quotation 12

"Patients tend to feel intimidated by the medical profession and by the use of medical jargon. Jargon places barriers between the patient and the doctor."

Quotation 13

"If you are told that we are "finished" with you so you are discharged, that can be really upsetting to some people. It can make them feel abandoned. Doctors have to be a lot clearer what the process is going to be and what's going to happen."

Quotation 14

"Overall I was handled appropriately. I was asked "Are you happy to be discharged?", as long as that was asked I am happy to be discharged."

Quotation 15

"The doctor told me this: "We will discharge you if you are happy with that?" It would be frustrating for the doctor if I said, "No I am not happy"….what more could they do!"

Quotation 16

"If I wasn't suffering, I wouldn't be so worried! I live alone, I could not shop for myself. I couldn't get out. I went two days without food. I couldn't sleep because of the urticaria. I felt so bad. I was thinking silly things like putting a rope round my neck. These stupid things flash into your mind."

Quotation 17

"Notice of discharge is not appropriate; these clinics are busy, if you did the treatment you don't need another appointment to be told that again. If it's appropriate to be discharged why clog the clinic even more?"

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Document: Reply to Mr Adrian Aldcroft (Editor to the BMJ Open)

Date: 30th September 2016

Editor's comments:

Before we can progress with your submission, please complete and include a COREQ check-list, ensuring that all points are included and state the page numbers where each item can be found: the check-list can be downloaded from here: http://www.equator-network.org/reporting-guidelines/coreq/

Corresponding author's reply:

- The COREQ Checklist has been completed
- All points related to the needs of the checklist have been listed and further explained in the manuscript.
- Page numbers where each item can be found have been stated in the checklist

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Table 1 Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

DOMAIN 1: RESEARCH TEAM AND REFLEXIVITY

PERSONAL CHARACTERISTICS

1. Q: **Interviewer/facilitator**: Which author/s conducted the interview or focus group?
   A: Nur Ainita Harun (First author, female researcher) conducted the interviews
   Page 5

2. Q: **Credentials**: What were the researcher's credentials? E.g. PhD, MD
   A: MBBS (Malaya), DDSc (Dermatological Sciences, Wales)
   Page 1

3. Q: **Occupation**: What was their occupation at the time of the study?
   A: Research fellow (Postgraduate PhD student)
   Page 1

4. Q: **Gender**: Was the researcher male or female?
   A: Female
   Page 5

5. Q: **Experience and training**: What experience or training did the researcher have?
   A: NAH is a clinician trained in internal medicine and dermatology. NAH received training in qualitative interviewing and transcription analysis, and conducted mock interviews before interviewing participants.
   Page 5

RELATIONSHIP WITH PARTICIPANTS

6. Q: **Relationship established**: Was a relationship established prior to study commencement?
   A: No. NAH did not know any of the participants before the study commenced.
   Page 6

7. Q: **Participant knowledge of the interviewer**: What did the participants know about the researcher e.g. personal goals, reasons for doing the research?
   A: The participants only knew that NAH was a dermatology clinician who was currently a full time researcher.
   Page 6

8. Q: **Interviewer characteristics**: What characteristics were reported about the interviewer/facilitator? Bias, assumptions, reasons and interests in the research topic
   A: NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumption was made that interviewer bias would be minimised by one person carrying out all the interviews.
   Page 5

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DOMAIN 2: STUDY DESIGN

THEORETICAL FRAMEWORK

9. Q: **Methodological orientation and Theory:** What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
   A: In this study a thematic analysis, a method for identifying, analysing and reporting patterns within data,[22] was conducted which involved searching repeated patterns (themes) across all data sets.
   Page 8

PARTICIPANT SELECTION

10. Q: **Sampling**: How were participants selected? e.g. purposive, convenience, consecutive, snowball
    A: Participants were selected using a convenience and purposive sampling methods.
    Page 5

11. Q: **Method of approach:** How were participants approached? e.g. face-to-face, telephone, mail, email
    A: After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2).
    Page 7

12. Q**: Sample size:** How many participants were in the study?
    A: In the study, 64 consultations were observed and 56 patients were interviewed.
    Page 6

13. Q: **Non-participation**: How many people refused to participate or dropped out?
    A: Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.
    Page 14

SETTING

14. Q**: Setting of data collection:** Where was the data collected? e.g. home, clinic, workplace
    A: The study took place in the dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff.
    Page 5

15. Q**: Presence of non-participants:** Was anyone else present besides the participants
    A: Yes. In 17 interviews a family member of the patient was present.
    Page 16

16. Q: **Description of sample:** What are the important characteristics of the sample?

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A: The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews.
Page 5

DATA SATURATION

17. **Interview guide:** Were questions, prompts, guides provided by the authors?
A: Yes. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed.
Page 5

18. **Repeat interviews:** Were repeat interviews carried out? If yes, how many?
A: No repeat interviews were carried out and the participants did not provide feedback on the findings.
Page 7

19. **Audio/visual recording:** Did the research use audio or visual recording to collect the data?
A: Yes. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and it was audiorecorded.
Page 7

20. **Field notes:** Were field notes made during and/or after the interview or focus group?
A: Yes. Field notes were made during the interviews and reflective notes made afterwards.
Page 8

21. **Duration:** What was the duration of the interviews or focus group?
A**:** Mean interview time was 20 minutes (range 5-40 minutes).
Page 16

22. Data saturation: Was data saturation discussed?
A**:** Yes. Data saturation was achieved after 41 interviews.
Page 16

23. **Transcripts returned:** Were transcripts returned to participants for comment and/or correction?
A**:** No. Transcripts were not returned to participants for comment. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion.
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DOMAIN 3: ANALYSIS AND FINDINGS

DATA ANALYSIS

24. **Number of data coders:** How many data coders coded the data?
    A: Three of the authors were involved in the data coding (Figure 1).
    Page 8

25. **Description of the coding tree:** Did authors provide a description of the coding tree?
    A: Yes, a description of the coding tree is provided under the headings : "Patients' attitudes to discharge", "Four key considerations when taking discharge decisions" and "Factors contributing to an inappropriate discharge" at pages 17-20.

26. **Derivation of themes:** Were themes identified in advance or derived from the data?
    A: In this study a thematic analysis, a method for identifying, analysing and reporting patterns within data,[22] was conducted which involved searching repeated patterns (themes) across all data sets.
    Page 8

27. **Software:** What software, if applicable, was used to manage the data?
    A: N Vivo 10 Qualitative Data Analysis Software
    Page 8

28. **Participant checking:** Did participants provide feedback on the findings?
    A: No. The participants did not provide feedback on the findings.
    Page 7

REPORTING

29. **Quotations presented**: Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number.
    A: Participant quotations are presented. Quotation numbers are used but not participant numbers.
    Page: Refer to the manuscript where the quotations are placed.

30. **Data and findings consistent**: Was there consistency between the data presented and the findings?
    A: Yes. Pages 8-20

31. **Clarity of major themes:** Were major themes clearly presented in the findings?
    A: Yes. These are presented in the Results and the Discussion.

32. **Clarity of minor themes:** Is there a description of diverse cases or discussion of minor themes?
    A: Yes: pages 17-20

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Understanding clinician influences and patient perspectives on outpatient discharge decisions: a qualitative study.

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1. Title of the article

Understanding clinician influences and patient perspectives on outpatient discharge decisions: a qualitative study.

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5. Five keywords relevant to the content of your manuscript

   Outpatient discharge, patient's voice, discharge decision-making, discharge process, patient's experience

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7. Number of Tables: 4, Number of Figures: 1 and Number of references: 35
Number of supplementary files for online only publication: 3 Appendices in one file

ABSTRACT

Objective

To observe the influences on clinicians when discharging patients, to explore patients' perspectives concerning their discharge or follow-up decision and to identify what patients think is important for clinicians to consider when taking a discharge decision.

Design

Qualitative study involving observations of consultations and semi-structured interviews with outpatients.

Setting

National Health Service outpatient clinics at a university hospital secondary referral centre.

Participants

64 consultations were observed followed by 56 interviews with patients over 18 years old.

Main outcome measure

Analysis of patients' perspective and expectations concerning whether or not they were discharged.

Results

25 types of influences were observed to be influencing the discharge decision process. 25 types of influences were observed to be influencing the discharge decision process. All 31 discharged patients appeared to accept the clinicians' decision, however 10 (22%) of those patients later expressed disappointment. Patients' discontent was due to perceived clinicians' uncertainty in diagnosis (patients mentioning = 2), poor acceptance of the diagnosis (2), disease not "cured" (4), differing perception on medical needs (2), lack of concern for job demands (1), felt uninvolved in the decision making (4), feeling rushed (3), prolonged open appointment (2), pushed to seek private care due to healthcare budget constraints (2), language barrier (1), and not keen to continue follow-up with GP (2). Patients were happy when there was certainty of the diagnosis (19), clear treatment plan (16), advised on treatment side effects (7), given a contact number if symptoms recurred (4), considered their travelling and job demands (3).

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Conclusions

This study highlights the importance of accurately perceiving patients' perspectives in ensuring the appropriateness of outpatient discharge. There was a disparity between patients' and clinicians' perception on what was an appropriate discharge. This included discrepancies concerning diagnostic certainties, private health care as an alternative, need for easy re-access and choice of words surrounding discharge. Medical education should include handling these issues.

STRENGTHS AND LIMITATIONS OF THIS STUDY

Strengths

- Data was derived from direct consultation observations by a single observer.
- The qualitative method used, interviewing patients immediately after discharge, encouraged patients' honesty about their experiences, when reassured that their comments would not affect further treatment.
- The usage of a topic guide during interviews focused patients specifically on the discharge decision process.

Limitations

- The study was based on only one centre and may not be a true reflection of discharged patients in general.
- The findings may have been affected by the clinic organisation or local discharge policies where it is possible that clinicians in a less busy clinic with more auxiliary support may interact with patients differently.
- The finding of inappropriateness of discharge was a largely unexpected outcome of this study and the methodology of the study had not been planned to explore this. A further qualitative study needs to be carried out, focusing on interviewing only patients who were "unhappy" or dissatisfied with their discharge, to explore this important issue further.

MANUSCRIPT

INTRODUCTION

Outpatient discharge decision-making occurs across the whole of medicine; it has a critical influence on service efficiency and patient satisfaction but very little is known about it. There

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are 82.1 million UK outpatient hospital visits annually.[1] At every consultation the clinician takes an implicit or explicit decision to discharge or see the patient again. Clinicians are under pressure to discharge patients to increase capacity.[2] Although strategies [3-5] have aimed at reducing secondary care demand, patients still prefer to see consultants rather than general practitioners (GPs).[6] Clinicians balance their perception of patients' needs, ethical awareness and the intricate influences surrounding discharge in order to take appropriate decisions.[7] Patients' attitudes towards their disease, wishes and their behaviour are also key considerations.[8,9] Clinicians therefore have to contend with complex influences, including possibly inaccurate perception of patients' expectations,[8-10] and the desire to discharge "difficult" patients [8,10,11] while continuing to review patients they know well.[8,9] There is a real risk of biased clinician decision-taking [8,12] .

Few studies[13-16] have examined what outpatients think about their discharge. Seeking to understand patients' views[17-19] may improve patients' discharge experience. Considering patients' wishes over follow-up preference may minimise unneeded appointments. Improved communication [8,9,15,17-19] and explanation of reasons behind discharge[9] may alleviate distress. Lack of planning of care around discharge[15] may result in an unhappy patient and family: incorporating patients' perspectives in the discharge process is critical.[7,8,15-19]

The main aim, that is the overall objective of this study, was to explore patient views about the outpatient discharge process, based on their recent experience. The research questions, i.e. the current objectives that this study was designed to answer, were as follows: (1) to observe what influenced clinicians before discharging patients, (2) to explore patients' perspectives concerning their discharge or follow-up decision and (3) to identify what patients think is important for clinicians to consider when taking a discharge decision.

METHODS

Participants

South-East Wales Local Research Ethics Committee gave ethical approval. The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews. NAH, first author and female researcher conducted the interviews. NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumptions were made that the interviewer biased will be minimised by one person carrying out the interviews. NAH is a clinician trained in internal medicine and dermatology. She received training in qualitative interview and transcription analysis, and conducted mock

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interviews before interviewing participants. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed.

Sampling

The study participants were selected from a convenience population using purposive sampling methods. The convenience population was the population of general adult dermatology outpatients attending the outpatient clinics. "Purposive" sampling is a type of nonprobability sampling technique. As this study was about understanding how adult dermatology outpatients were discharged from the clinic, the participants were selected, based on the judgment of the researcher NAH, because they were dermatology patients attending outpatient clinics with the likelihood of being discharged. We considered the optimum sample size of interviewees, being informed by a previous study[16] where saturation of information from interviewees was achieved at the 46th face-to-face interview, and recruited an additional 15 patients to avoid bias and increase the robustness of the data.

The recruitment process

Recruitment strategy was to include a variety of patients of different gender, ages, job and education status and a variety of skin conditions, simple, complex, medical and surgical. The researcher selected clinic sessions which had both surgical and medical patient attendances. Recruitment was aimed at patients who were likely to be discharged. Before each clinic session, the consultant reviewed the patient appointment list and case notes and informed the researcher of patients who were "potential" candidates for the study. The researcher would agree or disagree with the consultants' suggestion based on the demographic characteristics of patients whom she had interviewed earlier, in an attempt to recruit patients with a wide range of demographic characteristics and diseases. The cooperation of the consultant was critical because of his/her background knowledge of patients' problems, circumstances, and disease severity.

When a patient was called in to the consultation room, the consultant sought verbal consent for the consultation to be observed. The researcher was then introduced to the patient and the patient's agreement reconfirmed. Following the consultation, the consultant would again check the patient's agreement and the researcher then interviewed the patient in a separate room. After each interview the researcher would wait for the consultant to call her in for the next patient. It was difficult to keep a good balance of surgical and medical cases because most of the patients who refused to be interviewed were those with complex, medical skin conditions. NAH did not know any of the participants before the study commenced. The participants only knew that NAH was a dermatology clinician who is currently a full time researcher.

Data collection and analysis

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In the study, 64 consultations were observed and 56 patients were interviewed.

Consultation observations

The aim of the consultation observations was to observe what influenced clinicians before discharging patients. The observations of patients' discharge during the consultations with consultants were used to compliment the subsequent patient interviews. The researcher's status as a nonparticipant observer was made clear to consultants and participants. Extracting what influences the consultants' discharge decision taking process can be difficult because the observer can only make assumptions concerning these influences. In order to make note-taking of observations of consultations more structured, a "Consultation Observation Checklist" was used (see Appendix 1) to record observations of how clinicians took discharge decisions. The checklist was developed based on discharge influences identified in the literature review and from previous clinicians' interviews.[8-10] It was impossible to collect everything during the observation process, therefore it was necessary to gain early insight into what interactions take place during the decision process.[20] The question, "How was the consultant's demeanour?" within the "Consultation Observation Checklist" was designed to address whether, and if so how, the intents and ethos described by the consultants were enacted in practice. For example, as some consultants in a previous study[7] had stated that they displayed empathy when informing patients of their discharge, we used the observational approach to observe whether this was reflected in practice. The researcher observed the participants' speech, facial expressions and gestures used[21] during their discussions with patients. The researcher also noted whether the consultants tried to make sure that patients understood their diagnosis and how to self-manage before discharging them. The observation method was used to understand consultant behaviour within a naturalistic context, complementing, verifying and validating data extracted from participant interviews.[21]

During the observation of consultations the researcher NAH made multiple notes of any other aspects of the consultations that appeared to be of relevance, including recording the consultants' demeanour. In addition the researcher observed the type of factors influencing the consultants' discharge decision taking and recorded each influence using the "Consultation Observation Checklist".

The checklist data was analysed by counting the number of checklist influences recorded during each consultation and also by counting the number of consultations in which each influence occurred. These data were converted to percentages to make the comparison clearer. The checklist was piloted in eight consultation observations and altered based on that experience. New items not in the original "Consultant Observation Checklist" were added, including "Discharged due to a wrong referral".

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The structured recording of data assisted the subsequent manual analysis of how frequently these influences occurred with each consultant and in relation to the context of the decision being made. After each observation, the researcher looked through each influential factor and related it to the discharge or follow-up decision. The checklist helped us to identify patterns of what clinicians considered most before discharging patients and to understand how different patients were handled. For instance by observing the clinicians' demeanour made it possible to compare how clinicians reacted to different patients during the discharge decision making process. The consultant's demeanour, the patient's verbal and nonverbal responses such as facial expressions were correlated with the list of influential factors. These observations were also interlinked with the clinic ambience and circumstances which occurred during the whole discharge decision making process. For example, one consultant asked an elderly patient whether she could apply the cream at home and be discharged, but the patient insisted on a follow-up because of the lack of assistance since she was living on her own. Each consultation was analysed using this method. Outcomes which were similar were categorised under the same heading (influential factor). One of the limitations of this data analysis was that categorical data handling may result in a conceptual grid and there may be new categories or influences missed. However, this limitation was addressed by the pilot observation study.

Patient interviews

The aims of the patient interviews were to explore patients' perspectives concerning their discharge or follow-up decision and to identify what patients think is important for clinicians to consider when taking a discharge decision. Immediately after the consultation patients were invited for interview. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and it was audiorecorded. At the interview end, a question such as "is there anything more you would like to add?" was asked to encourage further patient ideas. We planned interviewing at least 10 more patients after reaching saturation. No repeat interviews were carried out and the participants did not provide feedback on the findings. It would have been ideal for the researcher to interview each consultant immediately after the observation session to confirm whether each factor really had an influence on discharge decision-making process. However, the prime focus of this study was to gain the patients' insights.

Coding themes and subthemes of the data set

Field notes were made during the interviews and reflective notes afterwards. Transcripts were not returned to participants for comment. Three of the authors were involved in the data coding (Figure 1). Interviews were transcribed and manually analysed by coding data in the printed transcript margin.

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In this study, a thematic analysis was conducted which involved searching repeated patterns (themes) across all data sets. A theme captures something significant or meaningful about the data set in relation to the overall research question and is not necessarily dependent on how little or often such a theme appears throughout the data set. The researcher's judgement is critical to decide what a theme is. The researcher (NAH) transcribed the interviews and reviewed the data, generated initial codes in a structured fashion and collated the codes into potential themes. These themes were then checked to confirm whether they related well to the coded extracts within the entire data set and finally each theme was clearly defined and named. [22]

Duplications were removed and similar categories grouped and reduced into broader sub-themes. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion. Analysis focused on the patients' perception of discharge appropriateness, patients' discharge expectations and what they thought clinicians should consider before discharging them. Transcripts were further analysed using NVivo 10, Qualitative Data Analysis Software to aid data organisation.

Statistical analysis

A "descriptive statistical analysis" of the data is reported. This consists of reporting percentages of items observed.

RESULTS

Consultation observations

Participants (consultants)

Observations of 64 dermatology consultations took place in a dermatology outpatient clinic. Table 1 describes the characteristics of the dermatology consultants who took part. All but one consultant agreed to participate.

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Table 1. Demographic characteristics of the consultant dermatologists (N=7)

Consultant Dermatologists	**Number (N)**
Male	5
Female	2
Mean age (range)	50.8 years (38-56)
Indigenous British	4
Ethnic minority	3
Type of NHS Contract	
Full time	7
Part time	0
Also working in private practice	3
Years of clinical experience in dermatology	
30-40 years	2
20-29 years	3
10-19 years	1
< 10 years	1
Main special interest in dermatology	
Medical	4

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Surgical	2
Paediatric	1

Consultation Observations

Table 2 describes the number of consultations, out of the total 56, in which each "Consultation Observation Checklist" influence was observed.

Table 2. Number of consultations in which each "Consultation Observation Checklist" influence was observed (56 consultations observed)

	N= Number of consultations in which the influences were observed	Percentage (%)
DISEASED BASED INFLUENCE		
Type of diagnosis	56	100
Certainty of the diagnosis	39	70
Disease progression	26	46
Comorbidities	15	27
Type of treatment	41	73
Response of treatment	38	68
Completion of treatment	20	36

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Treatment side effects	12	21
Disease monitoring	28	50
Usage of dermatology treatment guidelines	5	9
PATIENT BASED INFLUENCE		
Age	3	5
Gender	0	0
Culture	0	0
Communication (language barrier)	2	4
Mobility	0	0
Distance	5	9
Circumstances surrounding patient's life	0	0
Carer or family member to assist at home	19	34
Cognitive ability	0	0
Learning difficulties	0	0
Psychological concerns	2	4
Patient's quality of life	4	7
Understanding of the disease	0	0
Patient's acceptance of disease	28	50
Patient's ability to self-manage treatment	36	64
Patient's compliance with medication	0	0
Patients' initiative to engage with support groups	0	0
Patient's concerns about job	3	5
Patient's expresses wish to be discharged	2	4
PRACTICE BASED INFLUENCE		
Academic interest	5	9
Reassure patient easy reaccess to secondary care	27	48

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Joint colleague discussion	7	13
Nurse assisted in explaining treatment	3	5
Ascertain patient-GP relationship	2	4
Ascertain GP's skills in handling dermatology cases	2	4
Ascertain GP's willingness to share care	0	0
Ascertain availability of treatment in secondary care	16	29
Discharge due to wrong referral	0	0

25 types of influences were observed to be influencing the discharge decision process. Table 3 presents the relationship of observed influential factors to the likelihood of discharge or followup, based on the "Consultant Observation Checklist" and other recorded observations.

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Table 3. Relationship of observed influential factors to likelihood of discharge or followup

(GP = general practitioner)

Observed influential factors (N=25)	**Patient is likely* to be discharged if the influence aspect (column 1) is as follows:**	**Patient is likely* to be followed up if the influence aspect (column 1) is as follows:**
Type of diagnosis	Disease is self-limiting or simple	Disease is severe or complex
Certainty of the diagnosis	Diagnosis is confirmed	Biopsy is needed to confirm diagnosis
Patient's acceptance of the diagnosis	Understands and able to accept diagnosis	Doubtful about diagnosis accuracy
Type of referral	Wrong referral	Appropriate referral
Joint colleague discussion to confirm diagnosis	Clinician is confident of diagnosis	Clinician is unsure of diagnosis, needing joint colleague discussion to confirm diagnosis
Comorbidities	Patient with no other problems	Patient with multiple diagnoses
Guidelines	Treatment which does not involve guidelines	Treatment which involves guidelines (such as for melanoma)
Disease progression	Stable or asymptomatic	Recurrent
Disease monitoring	Treatment plan which can be	Treatment plan which needs

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	monitored by GP	hospital monitoring
Type of treatment	Topical treatment with minimal side effects	Ongoing systemic medication or biologics
Completion of treatment or "cured"	Tumour fully resected	Multiple tumours and recurrent tumours
Treatment response	Good treatment response	Poor treatment response
Treatment availability	Not available or treatment not possible in the NHS	Many treatment options available in the NHS
Patient age	Younger patients	Older and frail patients
Patient attitude	Patients who appears confident	Patients who have a long term relationship with consultant
Carer	Presence of carer or family	Living alone
Communication	Ability to communicate well	Language barrier
Job	Busy	Retired
Distance	Lives away and travelling difficulties	Easily mobile, independent
Psychosocial concerns	None	Present, and lack of resources to handle concerns
Skin disease burden	Coping well	Not coping well.
Self-manage	Understood well and agreed to self-monitor disease	Difficulties in coping or lack of support to monitor disease
GP relationship	Good relationship with GP	Doubtful of GP's expertise
GP's skills	Skillful GP or GP with dermatosurgical facilities	Perceived inadequate GP dermatology skills

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Wishes or concerns	Patient accepts advice after addressing wishes or concern	Unrealistic expectations or too many concerns making it impossible to handle in one clinic setting

* "…is likely" refers to the opinion of the researcher NAH, based on witnessing and recording the 64 consultations. NAH was also informed by interviewing 56 patients, spending over 100 hours transcribing and reflecting on the interviews' content and by detailed discussions with the research team.

During the observation of consultations, the gender, ethnicity and years of experience of consultants were not perceived to relate to patients' satisfaction or dissatisfaction concerning the decision whether or not to discharge them. However one patient with a different ethnic background to the consultant had difficulty understanding the disease management plan and the patient was not discharged. Consultants who worked in private practice appeared to be more confident in providing information to patients if the skin condition was not treatable under the NHS.

Pattern of discharge of practice

The pattern of discharge practice differed depending on various influences. Consultants had their own personal demeanour and unique method when handling discharge: all maintained good eye contact and expressed concern. Twenty-six (46%) consultations were interrupted by colleagues or by phone calls. Consultants kept within the standard consultation time when the problem was simple. However, six consultants spent longer with patients who had special concerns about their skin. Before discharging a patient referred for a diagnosis (after many years of uncertainty), the consultant took time to explain the diagnosis, treatment possibilities and that cure was unlikely. When interviewed the patient said she was less anxious, relieved to have a confirmed diagnosis and was happy to be discharged (Quotation 1). The possible implications to this finding require further thought and development of strategies to improve clinic discharge management by reducing disruption of clinic consultations. As part of a wider study[8] 40 consultants were asked about the strategies that could be used to improve discharge decision taking: one of these was to train juniors in effective time management. All consultants clearly explained the diagnosis to patients: in two instances the diagnosis was ambiguous but the patient was discharged after reassurance. Patients accepted their discharge readily after a good surgical outcome. An elderly patient appeared relieved when not discharged: she stated that despite normal clinical findings, she was followed up because the consultant had cared for her for years and understood her well. If treatment was complex and needed primary care blood

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monitoring, consultants tended to check on the patient's motivation to self-monitor. When discharging, one consultant always concluded by asking "Is there anything else I can help you with right now?"

Patient interviews

Participants (patients)

Fifty-six patients with medical, surgical, subacute and chronic skin conditions were interviewed immediately after their consultation had been observed (26 (46%) male, mean age 54 years, range 18 - 80). Table 4 presents the demographic characteristics of the patients. Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.

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Table 4. Demographic characteristics of the patients who were interviewed and whether they were discharged or not

Study Participants	Number	Percentage (%)	Discharged	Not discharged
Male	26	46		
Female	30	54		
Mean age (range)	53.9 years (18-80)			
Indigenous British	50	89		
Ethnic minority	6	11		
Education level				
Primary	1	2		
Secondary	31	55		
Tertiary	24	43		
Type of skin disease				
Medical	29	52		
Surgical	24	43		

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Unconfirmed diagnosis	3	5		
Type of job				
Employed	19	34		
Self-employed	4	7		
Retired	28	50		
University student	3	5		
Unemployed on benefits	2	4		
Diagnosis				
Non-melanoma skin cancer	7	13%	3	4
Melanoma	1	2%		1
Eczema	5	9%	1	4
Psoriasis	3	5%		3
Itchy rash	1	2%	1	
Acne vulgaris	3	5%	2	1
Post inflammatory hyperpigmentation	2	4%	1	1
Actinic keratosis	4	7%	3	1

Table 4 (continued)

Study Participants	Number	Percentage (%)	Discharged	Not discharged

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Allergic contact dermatitis to latex	1	2%	1	
Benign mole	2	4%	2	
Ingrown hair	1	2%	1	
Melasma	2	4%	1	1
Skin cancer and renal transplant	1	2%		1
Urticaria	2	4%	2	
Dermatofibroma	2	4%	1	1
Leg ulcer	1	2%		1
Onychomycosis	1	2%	1	
Nodular prurigo	1	2%		1
Lichen planus	1	2%	1	
Seborrheic dermatitis	1	2%	1	
Polymorphic light eruption	4	7%	3	1
Photosensitive dermatitis, photoaggrevated rosacea and UVA sensitivity	3	5%	1	2
Insect bites	2	4%	1	1
Rosacea	2	4%	2	
Uncertain diagnosis	3	5%	2	1
Total	56	100%	31	25

Details of patient interviews

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Data saturation was achieved after 41 interviews: 15 more confirmed saturation. Mean interview time was 20 minutes (range 5-40 minutes). NAH undertook all observations and interviews. Patient quotations are given in Appendix 3. In 17 interviews a family member of the patient was present. All 31 discharged patients appeared to agree with the clinician's decision to discharge them. However, when interviewed, 12 had not expected discharge. Two of these were happy: one was given the reassurance of easy clinic re-access and the other was relieved the treatment had finished (Quotation 2). The other 10 patients were unhappy, critical of the clinicians' attitude and incorrect perception of their needs. Eight had chronic disorders and had been followed-up long-term. Only two were at their first appointment. Three patients who had expected to be discharged were given a follow-up: one felt that there were limitations to the consultant's expertise, one perceived that no lesions were recurring and one felt nothing more could be done.

Eleven subthemes were identified, classified under three main themes: (I) Patients' attitudes to discharge: (1) patients' expectations, (2) patients' feelings and (3) patients' participation in decision making; (II) Key clinical considerations when taking discharge decisions: (1) diagnostic certainty, treatment plan and patient well informed, (2) patients' ability to cope and self-manage, (3) communicate with patients and address concerns and (4) efficient clinic organisation and clinical practice; (III) Factors contributing to inappropriate discharge: (1) diagnosis related, (2) treatment related, (3) patient disagreement with clinician's discharge practice and (4) projection of a "rushed" demeanour.

Coding themes and subthemes of the data set

Details of the coding themes and subthemes are presented in Figure 1.

I. Patients' attitudes to discharge

1) Patients' expectations

One patient with acne had not expected discharge despite significant improvement. He assumed he would not be discharged until completion of treatment. But another similar patient was relieved to be discharged, inferring that his disease was controlled.

2) Patients' feelings

An elderly patient, who experienced slight nerve damage secondary to excision of a skin cancer, agreed to discharge without any concern. However, a university student was dismayed by the decision to discharge, although his facial seborrhoeic dermatitis was clearly improving with medication.

3) Patients' participation in decision making

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Retired patients were less likely to engage in the discharge discussion. They accepted a more paternalistic approach and were less likely to negotiate follow-up (Quotation 3). When interviewed, only two of the retired patients (7%) preferred to have a discussion over whether or not to be discharged. Patients in employment and young adults apparently felt strongly that they should be involved in the discharge decision and two stated they would inform their consultant if they did not agree with the decision (Quotation 4). Patients who had chronic or complex problems were keen to be involved in the decision-making and preferred to be notified in advance about the possibility of discharge. Patients with surgical disorders were less demanding, saying they were impressed with the department's services. However, two patients stressed that they should not have been discharged without the dermatology surgeon (preferably) inspecting the surgical wound.

II. Key clinical considerations when taking discharge decisions

(1) Diagnostic certainty, treatment plan and patient well informed

Patients expected clinicians to be certain of their diagnosis (n=39) and provide a clear treatment plan (n=38). All stressed that providing clear information about their disease, patient information leaflets and website addresses is essential before discharge, empowering self-management and enhancing their confidence. Most patients with chronic diseases felt "safer" to be followed up, in case treatment needed changing. Fifty-one patients expected their management to be complete before discharge, including full investigation, exploring treatments and their responses and a final thorough examination (Quotation 5).

(2) Patients' ability to cope and self-manage

Patients are reluctant to be discharged if they feel unable to detect subtle changes heralding worsening (Quotation 6). Three psoriasis patients insisted that their disease chronicity meant they should never be discharged, even if well controlled, for fear of coping by themselves or missing new treatments. They felt more reassured being followed up by a dermatologist, even annually, than by their GP (Quotation 7): GPs need to have appropriate knowledge and to know when to re-refer.

(3) Communicate with patients and address concerns

Patients preferred phrases such as: "I don't need to see you again" or "You can now be taken care of by your GP" to the blunter "You are discharged". Fifteen patients said that clinicians should use simple terms when providing information. However during the observations, no clinicians used medical jargon. One (doctor) patient highlighted that clinicians should be reminded not to use medical jargon with a patient, to prevent them being confused (Quotation 8). Eight patients said that, when discharging, it is important that the physician has a confident

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demeanour to reassure the patient. Three patients mentioned that if a patient does not speak English, an interpreter must be used. During observations, in addition to the checklist items recorded (Table 2), the researcher NAH noted that two discharged patients apparently did not understand the diagnosis. One patient noticed the clinician was unimpressed by his spots until told they were itchy, illustrating patients' sensitivity to doctors' mannerisms and body language (Quotation 9). Two patients felt it important that clinicians ask whether patients are happy to be discharged (Quotation 10). However, one patient thought this a redundant question because he did not think anything would have been done if he replied he was unhappy (Quotation 11).

(4) Efficient clinic organisation and clinical practice

Seven patients were more likely to accept discharge if assured of quick re-access to specialist care if necessary. Twenty patients felt the long waiting time for first appointments or re-referrals was daunting. One patient with severe chronic urticaria said he almost committed suicide because of intolerable pain and itch and the long delays in dermatology referral (Quotation 12). Patients were happy if they perceived good communication existed between dermatologists and GPs or other specialty consultants involved in their care. Those with comorbidities were most appreciative of the reassurance that after discharge they would still be in good hands. Five patients mentioned the importance of coordination between GP and specialist. Two patients stated that discharge was more acceptable when notice of possible discharge is given during a previous consultation or when, after biopsy, the consultant wrote to the GP confirming a benign diagnosis. However, a (nurse) patient thought otherwise (Quotation 13). Patients with chronic conditions felt that warning of discharge would allow their mental preparation. Two surgical patients were keen to see the clinician who operated on them before discharge, to give them reassurance of the surgery's success and a sense of completeness.

III. Factors contributing to inappropriate discharge

The following results are based on information from all patients who were interviewed, and were not restricted to the ten "unhappy" patients.

1) Diagnosis related

Patients insisted that clinicians should confirm their diagnosis before discharge. One patient was unhappy because she felt the clinician was uncertain of the diagnosis. She was asymptomatic because the lesions had resolved while waiting for her appointment. She mentioned at the interview that she would have preferred an open appointment for easy access should the symptoms recur rather than a fixed follow-up. However, she did not say this to the clinician. Two patients stressed that patients' acceptance of their diagnosis is important before discharge. One patient was unhappy because he did not agree with the clinician's diagnosis and expected further investigations and monitoring. He was discharged because the clinician was confident of

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the diagnosis and explained there was no other treatment. The patient felt that the clinician was only interested in his perception of the diagnosis and was unwilling to probe further (Quotation 14). Another patient referred for diagnosis was appropriately given a follow-up. She felt that patients with rare diseases should never be discharged before making a definite diagnosis (Quotation 15).

2) Treatment related

One patient felt that patients with conditions with no cure should never be discharged, because of possible future advances. One student with seborrhoeic dermatitis insisted that his problem must be "cured" despite knowing this condition may recur. A patient with melasma was upset because he thought the clinician perceived his problem as purely cosmetic. A young female with acne highlighted that clinicians should provide further suggestions for dealing with disease or treatment complications, such as scarring.

3) Patient disagreement with clinician's discharge practice

One patient stated it was a hassle for her to be discharged and re-referred for surgical intervention if she later wanted this. She expected the clinician to understand her job demands and felt she should have been given more time to make a decision during the consultation. She said she was unable to express her disagreement due to her poor English and had felt uninvolved in the decision-making. Five patients were unhappy that their clinicians suggested they seek referral to a private dermatologist: actually the clinicians were informing patients about treatment only available in the private sector. Two patients did not understand NHS service limitations and felt the doctor was "following the rules" rather than prioritising the patient's best interests (Quotation 16).

4) Projection of a "rushed" demeanour

Three patients felt upset because their clinicians appeared rushed. The patients perceived that the clinician wanted to "wrap up" the consultation and discharge them to save time. These patients were still uncertain of their diagnosis or had psychological problems. One patient said he did not express dissatisfaction because of how the clinician spoke (Quotation 17).

DISCUSSION

In this study the mean age of patients was 54 years. 55% of dermatology outpatients range from age 45-100 years old. [20] Forty-three percent of the patients interviewed reported having had tertiary education. This is a higher level than the general population. This may be partially explained by the recruitment hospital being based in a large city centre where residents are generally well educated.

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Accurate perception and certainty of information

The researcher observed that in all consultations in which the decision was taken to discharge the patient, all patients and dermatologists gave the impression of agreeing with and of being content with the decision to discharge. However this study has revealed that there may be major discordance between patients' demeanour and apparent acceptance of discharge decisions, giving the impression that they were content with the decision, and patients' actual views.[23] Although clinicians endeavoured to address patients' needs, expressed concern and confidently arranged discharge, they mainly focused on medical issues[24] and were unaware of some patients' discontent over the discharge itself. Moreover, no patients objected to their discharge.

Clinicians may be unwittingly biased because of overconfidence,[8,25] or previous individual experiences.[26] Skilled expertise [27] is central to accurate clinical judgement, however a standardised tool[28,29] might in some instances be helpful to prevent bias.[8]

Inpatients are sensitive to subtle nuances of clinicians appearing courteous but not truly curious about patients' expectations and needs.[24] This study identified that outpatients also perceive these nuances, despite short consultations. Clinicians often focus on the basics of clinical medicine, such as diagnosing and monitoring treatment response. As problematic in the inpatient setting,[15] outpatient clinics are usually very busy and clinicians have little time to make decisions over discharge. If more time could be allocated to final visit consultations, this would allow more detailed addressing of patients' concerns and possibly reduce some of the bias inherent when judgements are made.

Patients expect continuity of outpatient care until the diagnosis is certain, but this may not always be possible. If clinicians were able to provide relevant information[8,9] to support understanding and self-care, this might increase patients' confidence in the discharge process. Jointly discussing a patient's treatment plan and encouraging further questions,[30] even if a patient seems to accept discharge, could uncover unmet needs.

Effective communication and patient engagement

Effective clinician-patient communication is a core attribute of high quality discharge-making.[9,15] For example, the avoidance of use of medical jargon may contribute to an atmosphere in which patients feel encouraged to ask questions.[13] If healthcare professionals, as part of the healthcare team, engage closely with patients with chronic conditions, the discharge decision process could be tailored to individual patient needs. The demeanour of clinicians has considerable unspoken influence on the consultation. Patients emphasised the importance of clinicians projecting confidence, respecting patients' views, using "kinder" words at discharge and displaying empathy. Most dermatology patients left the discharge decision entirely to clinicians. If patients are involved in the treatment decision,[31] even if disagreeing with the final

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decision, this may allow clinicians to gauge what matters most to a patient[32] before the decision is made. Clinicians may miss subtle hints of patients' needs if they discount patients' personal accounts,[25] dominate a subservient patient or ignore patient involvement in the decision process.[15,33] If there are conflicting views on the final decision this may encourage clinicians to try to understand the reasons for disagreement and thereby better inform their clinical judgement.

Addressing concerns and patient reassurance

Fully addressing all concerns of patients before discharge may in reality be impossible. Some patients felt "short-changed" at not receiving the "best" treatment for conditions with a strong cosmetic element. Aggressive discharge policies or tumour management guidelines may be challenged if patients express uneasiness at not being given a follow-up after surgery. Patient dissatisfaction might be reduced if clinicians ensured that patients understood the reasons behind hospital policies. Easy access to policy documents might enable this, if written in simple language. Dermatology patients are especially vulnerable to public comments of their appearance, because skin is integral to body image and self-respect. Although treatment was often not ideal, many patients interviewed preferred to be indefinitely under the dermatology care. Difficulties arise because of a mis-match between clinicians thinking they have "reassured" a patient and the patient's actual perception.[34]

Long re-referral waiting times add worry to patients already having difficulty coping. This concern may be addressed by making provision for open return appointments or direct access if needed. If patients are discharged with severe or chronic inflammatory skin disease that needs continued monitoring, a well-coordinated management plan between the specialist and the GP[9,15], clearly explained to the patient, will enhance the quality of care. Prior notification of discharge may help alleviate anxiety. Patients need reassurance that they will receive quality care after discharge from outpatients.[34] It may be helpful, especially for those patients who favour indefinite secondary care, to inform them of the framework of care provided by their GPs [9] and of their suitability for follow up in primary care. Identification of patients who need extra primary care input or emotional support after discharge may also result in the pre-empting of potential problems.

This study has some limitations. For example it is possible that some of the personal characteristics of the consultants, such as age, gender or ethnicity, may have been relevant to the patients' perceptions or acceptance of the discharge decisions. Our study was not designed to address this question, but no patients commented on these personal characteristics of the consultants.

IMPLICATIONS AND FUTURE RESEARCH

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The degree to which patients accept discharge varies widely: each patient's level of concern arises from their individual belief system or expectations. Patient engagement in the discharge process could contribute to the appropriateness of discharge decisions. Up to now, the patients' voice in the discharge decision has largely been ignored. However there is increasing motivation to ensure that clinical decisions are efficient and appropriate, to enhance care and for reporting performance. When taking the decision to discharge, clinicians using empathetic body language may help alleviate patients' anxiety. The clinical challenges require an appropriate mixture of coaxing and empathy along with the assessment of treatment response and consideration of the diagnosis. It would be appropriate to train clinicians to think and decide about discharge systematically: this would encourage clinicians to consider the patient's overall health, the clarity of the treatment plan, the patient's ability to apply treatment and to cope with treatment side effects. The wide range of issues identified by patients as important provides evidence to support targeted clinical training.

This study identifies for the first time that many patients on being discharged from outpatients may agree with the clinician to being discharged, apparently willingly, but in reality are unhappy with the decision or the way it was managed. It is important that clinicians should be aware of this possibility and seek to modify the way that they take discharge decisions to ensure that the patient's true feelings are taken into account. This flags up the need for clinicians to involve patients in discharge decision making in a structured systematic manner.

CONCLUSION

This study highlights the importance of accurately perceiving patients' perspectives in ensuring the appropriateness of outpatient discharge. This study provides a warning to clinicians that discharging a patient is even more complicated than it seems, and has opened a Pandora's Box of patients' attitudes surrounding discharge decisions. It highlights the importance of considering patients' perspectives in ensuring the appropriateness of outpatient discharge**.** This may be addressed by clinicians trying to include patients in discharge decisions and by understanding and addressing their wishes, especially with dermatology patients whose confidence relates to their body image. There is a need for a systematic approach to develop a science of discharge. We need to ascertain which information is critical to consider prior to discharge and to understand how clinicians can gain an accurate perception of patients' expectations and avoid bias. Conflicting views relating to discharge will continue between some clinicians and patients unless clinicians more fully understand patients' expectations and are able to handle their concerns. Perhaps after beginning to hear the patient's voice surrounding discharge, clinicians should be encouraged to develop the skills needed to take consistently high quality and appropriate discharge decisions.

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Contributors: NAH carried out a literature search, study design, ethical, and Research and Development approval, data collection, data analysis, data interpretation and wrote the first draft of the manuscript. VP contributed to study design, supervision of the project and writing of the manuscript. AYF and SS contributed to study design, supervision of data collection, analysis of data, and writing of manuscript.

Guarantor: Cardiff University

Ethics approval:

South East Wales RECs Committee-Committee C

REC: 11/WSE03/4 Date approved: 24th February 2011

The participants gave informed consent before taking part in the study.

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Role of the study sponsor: The sponsors had no role in the gathering or analysis of the data and no role in the writing of the manuscript or the decision to submit for publication.

Statement of independence of researchers from funders: No funding, therefore not applicable.

Transparency declaration: The lead author affirms that this manuscript is an honest, accurate and transparent account of the study being reported; no aspects of the study have been omitted. Any discrepancies from the study as planned have been explained.

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Trial registration details: Not relevant because this was not a clinical trial

Data sharing statement: No additional data available.

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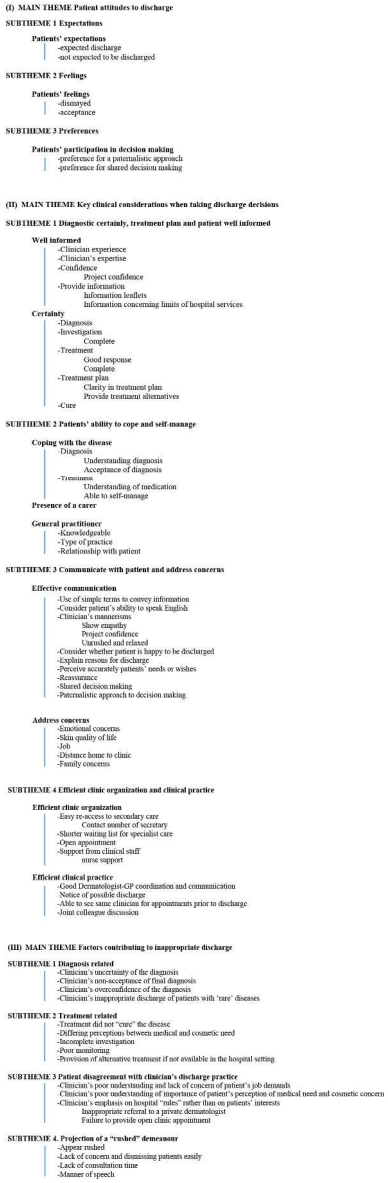

Figure 1. Details of the coding main themes and subthemes

97x293mm (300 x 300 DPI)

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SUPPLEMENTARY FILE: APPENDICES

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APPENDIX 1

Consultation Observation Checklist

Factors Influencing Discharge Decisions in Outpatient Dermatology

Observation of Dermatology Consultations

Observer: Non participant

Date	
Patient Demographics	
Age	
First visit or follow up	
Discharged or follow up	
Length of consultation	
Diagnosis	
Medical	
Surgical	
Sex	
Ethnicity	
Education level	
Employment Status	
Factors which influence clinicians'' discharge decisions	N= Number of consultations in which the influences were observed
DISEASED BASED INFLUENCE	
Type of diagnosis	
Certainty of the diagnosis	
Severity of the disease	
Disease progression	
Comorbidities	
Type of treatment	
Response of treatment	
Completion of treatment	
Treatment side effects	
Disease monitoring	
Usage of dermatology treatment guidelines	
PATIENT BASED INFLUENCE	
Age	
Gender	
Culture	
Language barrier	
Mobility	
Distance	
Circumstances surrounding patient's life	
Carer	

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Cognitive ability	
Learning difficulties	
Psychological concerns	
Patient's quality of life (how was it assessed?)	
Understanding of the disease	
Patient's acceptance of disease	
Patient's ability self-manage treatment	
Patient's compliance to medication	
Patients' initiative to engage with support with groups	
Patient's concerns	
Patient's wishes	
PRACTICE BASED INFLUENCE	
Academic interest	
Reassure patient easy reaccess to secondary care	
Joint colleague discussion	
Nurse assisted in explaining treatment	
Ascertain patient-GP relationship	
Ascertain GP's skills in handling dermatology cases	
Ascertain GP's willingness to share care	
Ascertaining availability of treatment in secondary care	
Discharge due to wrong referral	

Reflection box

How was the consultant's demeanour? _____

Did the clinician show information leaflets? _____

Was there medical jargon when explaining to the patient? _____

Did the clinician notify the patient of a possible discharge in the next visit? _____

Further comments: _____

Note:

Definition of some terms used

"Understanding and acceptance of diagnosis by the patient".

This was assumed by the observer noting that patients nodded and smiled and told the consultants that they understood and accepted the diagnosis when asked by some of the consultants.

"Acceptance of disease by the patient". This was assumed by the observer if the patient nodded in agreement and agreed with the diagnosis told by the consultant.

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"Understanding of disease by the patient". This was assumed by the observer if the patients nodded, smiled and said "yes" when asked whether they understood what the diagnosis was and how to take or apply medication.

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APPENDIX 2

Patient Interview Guide

Factors Influencing Discharge Decisions in Outpatient Dermatology

Introduction

The research student will introduce herself and thank the patient for considering on being part of the study. She will give a copy of the patient information sheet to the participant to read and she will also go through any queries pertaining to their participation in the study. If the patient agrees to be interviewed, then the patient will have to sign a consent form. Both the patient and the carer will be informed that the interview will be audio recorded and some statements may be published. However the interviewee will remain anonymous. The patient will be allowed to stop the interview at any time they wish.

Brief questions about the following:

Opening statement

I understand that you have been discharged. Did you expect to be [discharged / not to be discharged] when you came to clinic this morning? Yes/No

(EXPERIENCE of discharge)

So tell me, how do you feel about being [discharged/ not being discharge?]

Probe more

1. "Tell me what do you mean by that?"
2. Why do you feel this way?
3. "Tell me a little more about this."
4. "What was that like for you?"

(APPROPRIATENESS of discharge)

Do you think it was the appropriate for you to be [discharged/ not to be discharged?] Yes/No

Probe more

1. "Why is that so?"
2. "Can you tell me more about this?"
3. What are your concerns regarding the decision to discharge you?
4. Did the doctor address your wishes or worries appropriately?

(SHARED DECISION MAKING in discharge)

Did you feel that were involved in the process of making that decision to [discharging you or not discharging you?] Whom do you think should be involved in the process of discharging you?

(FACTORS INFLUENCING PATIENT'S EXPERIENCE regarding the discharge /not being discharge decision made by the clinician in the outpatient dermatology clinic)

Clinician related factors

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1. Are you confident that the clinician understood your case?
2. Did the doctor provide you with all the information necessary for you to self-manage prior to discharge?
3. Was the information clearly explained?
4. Would it be helpful if you had some warning about discharge in advance?
5. Probe more

> 1. "Why is that so?"
> 2. "Can you tell me more about this?"

Patient related factors

1. How much influence would your understanding of your disease influence the decision to discharge or not discharge you?
2. How much influence would your understanding of your medication influence the decision to discharge or not discharge you?
3. How would your level of ability to self-manage influence the decision to discharge or not discharge you?
4. How much influence would your wishes affect the decision to discharge or not discharge you?
5. How much influence would your type of job affect the decision to discharge or not discharge you?
6. How much influence would the distance of your home to the hospital affect the decision to discharge or not discharge you?
7. How much influence does your skin quality of life or in general affect the decision to discharge or not discharge you?
8. How much influence would the presence of a carer affect the decision to discharge or not discharge you?

Probe more

> 1. "Tell me more on these factors?"
> 2. "Can you give me an example or any experience relating to this?"

Practice related factors

1. In general, can you give me any ideas what can be done to improve the discharge process for patients?
2. In your opinion what do you think is important for the dermatologist to consider or discuss with you before discharging you, in this case?
3. Any suggestions about how the clinic administrative system should operate to improve the discharge process?

(TIMING of discharge)

Did you have any prior notice about the possibility of when you will be discharged before this? Yes/No

Thank you very much for your time. Is there anything else you would like to add?

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APPENDIX 3

Patients' Quotations

Quotation 1

"I have been going to the doctor since I was 15 and now I am 23. It has taken a long time to get to this stage, so I am very happy. It could have been a lot better if it was addressed a lot earlier. I understand that there is no cure. I understand how to deal with it. I am happy to be discharged because he explained to me clearly, and he has helped me understand my condition."

Quotation 2

"This acne has always been a problem in school and now I am discharged, it seems to me that it is the end of the treatment and my spot in skin should be cleared soon. I guess I feel more confident of myself."

Quotation 3

"They are the experts, I am not. I do not know enough, I rely totally on them."

Quotation 4

"Overall I was handled appropriately. I was asked "Are you happy to be discharged?", as long as that was asked I am happy to be discharged. If I still had active blisters and if he asked "Are you happy to be discharged?" I would have said "No". But since it has subsided a little bit I was okay with the discharge."

Quotation 5

"I did not expect to be discharged, at least not until the patch test was done. Patients would not expect to be discharged until all the tests are done."

Quotation 6

"Sometimes you don't realise that you are becoming unwell, therefore you need some kind of medical intervention from the hospital. I would like to have an expert to look out for these changes."

Quotation 7

"GPs have a broader understanding but they aren't specialised enough, they wouldn't be up to date with the latest treatment. No disrespect to GPs."

Quotation 8

"Patients tend to feel intimidated by the medical profession and by the use of medical jargon. Jargon places barriers between the patient and the doctor."

Quotation 9

"If you are told that we are "finished" with you so you are discharged, that can be really upsetting to some people. It can make them feel abandoned. Doctors have to be a lot clearer what the process is going to be and what's going to happen."

Quotation 10

"Overall I was handled appropriately. I was asked "Are you happy to be discharged?", as long as that was asked I am happy to be discharged."

Quotation 11

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"The doctor told me this: "We will discharge you if you are happy with that?" It would be frustrating for the doctor if I said, "No I am not happy"….what more could they do!"

Quotation 12

"If I wasn't suffering, I wouldn't be so worried! I live alone, I could not shop for myself. I couldn't get out. I went two days without food. I couldn't sleep because of the urticaria. I felt so bad. I was thinking silly things like putting a rope round my neck. These stupid things flash into your mind."

Quotation 13

"Notice of discharge is not appropriate; these clinics are busy, if you did the treatment you don't need another appointment to be told that again. If it's appropriate to be discharged why clog the clinic even more?"

Quotation 14

"This doctor here has got blinkers on, in other words I suppose he only sees what he wants to see. Even though the test did not come back what he thought it was, he's still got the same opinion."

Quotation 15

"I just want someone to know what it is. Whenever I see anybody, nobody knows what it is. It is just looked at and I have to go."

Quotation 16

"The doctor should have been able to prescribe the most efficient treatment for me; surely from the NHS, not to give me a private website! I pay tax all my life, I haven't come to a private dermatologist have I? I think the clinician is influenced by her perception of cost. From my point of view she was concerned about money with the NHS."

Quotation 17

"Because the way the doctor kind of explained it, I sort of agreed with the doctor even though I was upset". "It seemed to me that the doctor just couldn't get me out of the room quick enough."

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Document: Reply to Mr Adrian Aldcroft (Editor to the BMJ Open)

Date: 30th September 2016

Editor's comments:

Before we can progress with your submission, please complete and include a COREQ check-list, ensuring that all points are included and state the page numbers where each item can be found: the check-list can be downloaded from here: http://www.equator-network.org/reporting-guidelines/coreq/

Corresponding author's reply:

- The COREQ Checklist has been completed
- All points related to the needs of the checklist have been listed and further explained in the manuscript.
- Page numbers where each item can be found have been stated in the checklist

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Table 1 Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

DOMAIN 1: RESEARCH TEAM AND REFLEXIVITY

PERSONAL CHARACTERISTICS

1. Q: **Interviewer/facilitator**: Which author/s conducted the interview or focus group?
   A: Nur Ainita Harun (First author, female researcher) conducted the interviews
   Page 5

2. Q: **Credentials**: What were the researcher's credentials? E.g. PhD, MD
   A: MBBS (Malaya), DDSc (Dermatological Sciences, Wales)
   Page 1

3. Q: **Occupation**: What was their occupation at the time of the study?
   A: Research fellow (Postgraduate PhD student)
   Page 1

4. Q: **Gender**: Was the researcher male or female?
   A: Female
   Page 5

5. Q: **Experience and training**: What experience or training did the researcher have?
   A: NAH is a clinician trained in internal medicine and dermatology. NAH received training in qualitative interviewing and transcription analysis, and conducted mock interviews before interviewing participants.
   Page 5

RELATIONSHIP WITH PARTICIPANTS

6. Q: **Relationship established**: Was a relationship established prior to study commencement?
   A: No. NAH did not know any of the participants before the study commenced.
   Page 6

7. Q: **Participant knowledge of the interviewer**: What did the participants know about the researcher e.g. personal goals, reasons for doing the research?
   A: The participants only knew that NAH was a dermatology clinician who was currently a full time researcher.
   Page 6

8. Q: **Interviewer characteristics**: What characteristics were reported about the interviewer/facilitator? Bias, assumptions, reasons and interests in the research topic
   A: NAH undertook this research as part of a wider PhD project and thereby was highly motivated to maximise information received from the participants. The assumption was made that interviewer bias would be minimised by one person carrying out all the interviews.
   Page 5

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DOMAIN 2: STUDY DESIGN

THEORETICAL FRAMEWORK

9. Q: **Methodological orientation and Theory:** What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
   A: In this study a thematic analysis, a method for identifying, analysing and reporting patterns within data,[22] was conducted which involved searching repeated patterns (themes) across all data sets.
   Page 8

PARTICIPANT SELECTION

10. Q: **Sampling**: How were participants selected? e.g. purposive, convenience, consecutive, snowball
    A: Participants were selected using a convenience and purposive sampling methods.
    Page 5

11. Q: **Method of approach:** How were participants approached? e.g. face-to-face, telephone, mail, email
    A: After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2).
    Page 7

12. Q**: Sample size:** How many participants were in the study?
    A: In the study, 64 consultations were observed and 56 patients were interviewed.
    Page 6

13. Q: **Non-participation**: How many people refused to participate or dropped out?
    A: Sixty-four patients (excluding the pilot study) initially agreed to be observed and interviewed. However eight patients later changed their minds because four were in a hurry, three had other commitments and one because of poor English resulting in poor communication.
    Page 14

SETTING

14. Q**: Setting of data collection:** Where was the data collected? e.g. home, clinic, workplace
    A: The study took place in the dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff.
    Page 5

15. Q**: Presence of non-participants:** Was anyone else present besides the participants
    A: Yes. In 17 interviews a family member of the patient was present.
    Page 16

16. Q: **Description of sample:** What are the important characteristics of the sample?

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A: The study took place in a general dermatology adult outpatients clinic at the University Hospital of Wales, Cardiff and consisted of observation of consultations immediately followed by general dermatology adult male and female patient interviews.
Page 5

DATA SATURATION

17. **Interview guide:** Were questions, prompts, guides provided by the authors?
A: Yes. A study protocol, patient information sheet and patient topic guide were e-mailed to all consultants in the department, seeking their permission to observe consultations and have their patients interviewed.
Page 5

18. **Repeat interviews:** Were repeat interviews carried out? If yes, how many?
A: No repeat interviews were carried out and the participants did not provide feedback on the findings.
Page 7

19. **Audio/visual recording:** Did the research use audio or visual recording to collect the data?
A: Yes. After giving written consent, patients were interviewed face-to-face using a topic guide (Appendix 2) and it was audiorecorded.
Page 7

20. **Field notes:** Were field notes made during and/or after the interview or focus group?
A: Yes. Field notes were made during the interviews and reflective notes made afterwards.
Page 8

21. **Duration:** What was the duration of the interviews or focus group?
A**:** Mean interview time was 20 minutes (range 5-40 minutes).
Page 16

22. Data saturation: Was data saturation discussed?
A**:** Yes. Data saturation was achieved after 41 interviews.
Page 16

23. **Transcripts returned:** Were transcripts returned to participants for comment and/or correction?
A**:** No. Transcripts were not returned to participants for comment. Research team members independently validated 10% of transcripts against recordings and resolved differences through discussion.
Page 8

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DOMAIN 3: ANALYSIS AND FINDINGS

DATA ANALYSIS

24. **Number of data coders:** How many data coders coded the data?
    A: Three of the authors were involved in the data coding (Figure 1).
    Page 8

25. **Description of the coding tree:** Did authors provide a description of the coding tree?
    A: Yes, a description of the coding tree is provided under the headings : "Patients' attitudes to discharge", "Four key considerations when taking discharge decisions" and "Factors contributing to an inappropriate discharge" at pages 17-20.

26. **Derivation of themes:** Were themes identified in advance or derived from the data?
    A: In this study a thematic analysis, a method for identifying, analysing and reporting patterns within data,[22] was conducted which involved searching repeated patterns (themes) across all data sets.
    Page 8

27. **Software:** What software, if applicable, was used to manage the data?
    A: N Vivo 10 Qualitative Data Analysis Software
    Page 8

28. **Participant checking:** Did participants provide feedback on the findings?
    A: No. The participants did not provide feedback on the findings.
    Page 7

REPORTING

29. **Quotations presented**: Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number.
    A: Participant quotations are presented. Quotation numbers are used but not participant numbers.
    Page: Refer to the manuscript where the quotations are placed.

30. **Data and findings consistent**: Was there consistency between the data presented and the findings?
    A: Yes. Pages 8-20

31. **Clarity of major themes:** Were major themes clearly presented in the findings?
    A: Yes. These are presented in the Results and the Discussion.

32. **Clarity of minor themes:** Is there a description of diverse cases or discussion of minor themes?
    A: Yes: pages 17-20

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