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Exploring individuals' perceptions and acceptability of a 'wait and see' approach for managing self-limiting illnesses: A qualitative study

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ABSTRACT

Objective: To explore individuals' perceptions and acceptability of a 'wait and see' approach, and phrases to describe this, for managing self-limiting illnesses (those that typically resolve spontaneously).
Methods: Semi-structured interviews with a purposive sample of 30 Australians. Two researchers independently conducted a thematic analysis of interview transcripts, and all authors agreed on final themes.
Results: Four themes emerged: Interpretation of what 'wait and see' meant varied and encompassed whether individuals had already sought medical care; Individuals' experiences and circumstances influenced the acceptability of a 'wait and see' approach; Symptom management was perceived as the most reassuring phrase to describe this approach; Individuals highly valued clear communication about a 'wait and see' approach and wanted a collaborative and action-oriented plan for the waiting period.
Conclusion: Individuals generally accepted a 'wait and see' approach, although less so for some illnesses and in some circumstances. They wanted it at least presented as an option when appropriate, with 'symptom management' as the preferred terminology. Clear communication and collaborative decision-making were valued.
Practice implications: When 'wait and see' is a reasonable option, clinicians should communicate this to patients, support them in decision-making, and provide a plan for the waiting period if the option is chosen.

1. Introduction

Primary healthcare is typically the first encounter between patients and health professionals when illness arises, with general practitioners (GPs) the most common health professionals consulted [1]. Some of the conditions frequently seen by GPs are self-limiting, which usually resolve with or without treatment [2,3] (e.g., acute viral infections) and only require symptom management. No active treatment (also known as 'wait and see') is often a legitimate option for such conditions. For example, antibiotics for sore throat are usually considered unnecessary as they provide minimal benefits while introducing potential harm from side effects and antibiotic resistance [4,5]. Patients often overestimate the benefits of interventions and underestimate their harms [6]. When self-limiting conditions are treated unnecessarily, this can contribute to a false belief of the necessity and effectiveness of the treatment [7].

Researchers and clinicians commonly use various phrases such as 'do nothing' [8], 'watchful waiting' [9], 'wait and see' [10], 'watch and wait' [11], and 'no active treatment' [12], to describe or communicate the treatment option of observing and providing supportive management only. Supportive management can include interventions to help manage the symptoms (e.g., pain medication). Most existing research about the communication of this option has been conducted in the context of cancer screening and treatment. For other conditions, such as self-limiting conditions, there is a research gap in exploring how people perceive this option, whether terminology matters and factors that can influence the acceptability of such an option.

For example, The Choosing Wisely initiative, which focuses on de-implementing low-value care services, encourages patients to ask their healthcare professionals five questions – one of which is "What happens if I don't do anything?". In an Australian study that examined patients' use of the Choosing Wisely questions, several participants commented that they would not ask this question as they would never choose this option anyway [13]. As far as we are aware, no prior studies have investigated what patients think about a 'wait and see' option for self-limiting illnesses. This study aimed to explore individuals' perceptions and acceptability of a 'wait and see' approach, and phrases to describe this, for self-limiting illnesses commonly seen in primary care.

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2. Methods

2.1. Study design

This was a qualitative study that used semi-structured interviews.

2.2. Participants

We recruited a purposive sample of 30 participants between September and November 2022 by posting on Facebook community groups (Australia-wide) or distributing posters (Supplemental File) in several locations within the Gold Coast, Australia (e.g., shopping centre, GP clinic, community and university libraries). Participants were eligible if they lived in Australia, were ≥18 years old, were not a health professional, could speak English comfortably and provide written consent. Efforts were made to ensure a diverse range of participants regarding age, gender, and cultural background. All eligible participants received a study information sheet, consent form, and withdrawal form.

2.3. Data collection

One author (EA) conducted semi-structured individual interviews in person or via Zoom videoconference. The interview guide (Supplemental File) was developed based on a comprehensive review of relevant literature and previous work of the research team [5,14–17]. Participants' preferences towards aggressive versus passive approaches to healthcare were measured using the single-item Medical Maximizing-Minimizing question [15], and their preferences towards active versus more passive involvement in decision-making were measured using The Control Preference Scale with fixed order presentation [14,18]. These measures provide insight into participants' general healthcare inclinations, which could influence their views about 'wait and see' or treatment. The interviews were conducted in a private setting, either in a university meeting room or other venue convenient to the participant (e.g., videoconferencing, community library). The interviewer (EA) took field notes during and after each interview to capture additional observations and contextual details. The interviews lasted, on average, 34 min. Participants were compensated with AUD 30 gift card (about USD 20). The interviews were audio-recorded and transcribed verbatim using Otter.ai with manual validation by EA.

2.4. Patient and public involvement

Four individuals from the public reviewed the interview guide. We piloted the interview guide with two other individuals to refine the clarity of the questions. Responses to the pilot interviews were not included in the data analysis.

2.5. Data analysis

The research team included a female PhD researcher with a medical background (EA), a male postdoctoral research fellow with a medical background (MB) and a female clinical epidemiology professor with a clinical background (TH). The research team has been researching the natural course of illnesses and methods of presenting this information.

Two authors (EA and MB) independently analysed the interview data using thematic analysis. An inductive approach was applied. The analysis process was conducted using NVivo 12 and involved several iterative phases, as outlined by Braun and Clarke [19]. Both authors independently familiarised themselves with the interview transcripts through repeated readings to gain an overall understanding of the data. Both then engaged in capturing meaningful features relevant to the research question, focusing first on five randomly selected interviews and then including the remaining interviews in the analysis. The development of themes went through several discussions about overlapping and unique themes, and the researchers generated initial themes by grouping codes based on their similarities and patterns. These initial themes were reviewed, refined, and clustered to develop overarching themes. The researchers engaged in discussions to ensure the credibility and coherence of the emerging themes. Meetings and discussions involving all authors were conducted to resolve discrepancies and ensure consensus in identifying and interpreting themes. Participant recruitment ceased upon reaching data saturation.

3. Results

3.1. Participant characteristics

Of the 50 participation requests, 20 did not meet eligibility criteria or respond to interview time requests. Table 1 presents the characteristics of the 30 participants who were interviewed. There was representation across all age categories and education levels, and 87 % spoke English as their first language. Most (83 %) expressed a preference for active or collaborative decision-making involvement.

3.2. Themes

Four themes were identified:

3.2.1. Interpretation of what 'wait and see' meant varied and encompassed whether the individuals had already sought medical care

There were various interpretations of the meaning of a 'wait and see' approach, influenced by participants' assumptions about whether they had already sought medical care. Most participants thought it referred to waiting for the condition to get better on its own at home before seeking medical advice. Some described using natural remedies or over-the-counter medications to relieve symptoms.

> "I will go to the GP if I feel like I have already waited and it's not improving." P03 (female, 35–44)

Some thought it meant waiting, based on clinicians' advice, after a

Table 1
Participant characteristics.

Characteristic	n (%)
Interview mode	
Face to face	24 (80)
Video conferencing	6 (20)
Age category - years	
18–34	11 (37)
35–44	3 (10)
45–54	4 (13)
55–64	9 (30)
≥65	3 (10)
Gender	
She/Her	18 (60)
He/Him	12 (40)
Education	
Not completed high school	1 (3)
Completed high school	8 (27)
Certificate I-IV, Diploma, or apprenticeship	9 (30)
Bachelor's degree or equivalent	7 (23)
Postgraduate education (Master's or Doctoral degree or equivalent)	5 (17)
English as first language	26 (87)
Maximizer-Minimizer scale 1[a]	
Minimiser	22 (73)
Maximiser	5 (17)
Control Preference Scale[b]	
Active	15 (50)
Collaborative	10 (33)
Passive	5 (17)

[a] MM1 (Maximizer-Minimizer scale) assesses patients' preferences for aggressive versus more passive approaches to health care.

[b] CPS (Control Preference Scale) assesses patients' preferences to be involved in the decision-making regarding a health issue.

consultation.

"I'm just going to have to just forget about it and just do what the doctor says and wait and see". P28 (male, 18–34)

A few participants interpreted 'wait and see' as waiting to gather more information, either from tests or by searching for information themselves, before deciding what to do next.

"If you're not 100 % sure if it's needed, and it's some kind of super invasive surgery or something, then it might be better to do some more investigation." P08 (male, 55–64)

"Wait and see also means to me to find out a bit more about it on my own." P05 (female, 55–64)

A few participants interpreted 'wait and see' as waiting for the prescribed treatment to take effect.

"Wait and see how the cure or plan will go or how this medicine will solve the problem." P07 (female, 18–34)

3.2.2. Individuals' experiences and circumstances influenced the acceptability of a 'wait and see' approach

Participants indicated that trust in their treating clinicians, especially when they had a good and long-lasting relationship, would increase the acceptability of a 'wait and see' option for them.

"And I think that comes from who your GP is and what sort of rapport you have with them. Whether they are a GP that has invested enough to take the time to do that, and I think as a patient that's really really important." P12 (female, 55–64)

A 'wait and see' approach was perceived as more acceptable when participants had some experience or familiarity with the same or similar conditions.

"I have carpal tunnel, and usually when I wait and see and just rest my hand with the wristband or something, it became better and no need for cortisone injection" P07 (female, 18–34)

Some participants explained, *"Sometimes I prefer to go with the wait and see instead of go to the side effects of this treatment." P07 (female, 18–34)*.

They also felt comfortable waiting and seeing for self-limiting health issues that were likely to have a short duration and low risk of complications. Examples provided included viral infections, muscular pains, sprains, minor injuries, or general pain complaints.

"And I think that wait and see is [a] good answer with some health conditions that often resolve themselves" P04 (female 45–55)

From a prompted list of health issues (Supplemental File), participants were comfortable waiting and seeing for sore throat, sinusitis, gastroenteritis, acne, and tennis elbow. Some felt hesitant waiting and seeing for middle ear infections, acute cough, conjunctivitis, urinary tract infections, and impetigo. This reluctance was often attributed to factors such as severe pain, the contagious nature of the condition, or potential complications from these conditions.

Pain was a symptom that would dissuade many from waiting and seeing, especially if it persisted for longer than they expected it should.

"…if I'm really in a painful way, I will not prefer to wait and see, I will go with that treatment solution straightaway." P07 (female, 18–34)

"If it goes longer than it should be, that means there's something else that's going on, and then I would take another action for it." P01 (male, 18–34)

Other factors that contributed to hesitancy about waiting were if children were involved, individuals had already waited for improvement, or they had responsibilities and perceived treatment would make them better quicker.

"I'd probably follow it for myself. If it was my son or daughter, I might be a little bit more nervous taking it" P18 (male 55–64)

"Maybe I wouldn't consider a wait and see if, prior to the go into the doctor's, I've taken my own wait and see." P09, (female 18–34)

"A big thing would be my children and my grandchild. Like, if it was something that was taking me away from looking after them or doing things with them [….] so that would be a reason to do it [take treatment]." P22 (female, 55–64)

Individuals who were less accepting of a 'wait and see' approach reported opting for alternatives such as seeking a second opinion, searching the internet for information and remedies, and trying natural or non-prescription treatments.

"I would look at alternative methods, and I'm gonna get another, like another GP or different type of healthcare professional's perspective." P09 (female, 18–34)

"… I would Google things like natural therapies and things like that to do." P22 (female, 55–64)

3.2.3. 'Symptom management' was perceived as the most reassuring phrase to describe a 'wait and see' approach

Symptom management: Among the five phrases to express a 'wait and see' approach that participants were presented with, symptom management was preferred by most. Reasons for this included feeling more confident in their clinicians and feeling that their complaint has been heard and they are receiving the care they expected.

"Because symptom management gives that feeling that the GP or the doctor knows what they're talking about." P02 (female, 35–44)

"…I feel [it] has a bit more positive effect because it makes you feel that your concerns have been heard." P03 (female, 34–44)

For some, it also implied *"there is an actual process and plan" P09 (female, 18–34)* to help control their symptoms, including a backup if their health deteriorated or did not improve, and that they are actively involved in this plan.

"To me, it means we're both waiting to see, so we're on the same team." P05 (female, 55–64)

"I can get back to her if something changes […], and it just gives you that option to go back and relook at this condition or this problem you have." P05 (female, 55–64)

"It gives me an action because it keeps me involved in whatever the treatment plan is, even if there is no treatment. It's giving me an active role in that." P10 (female, 45–54)

However, a few participants expressed concerns that only managing symptoms might mean an underlying, potentially serious cause was being overlooked.

"If I think that all we're doing is symptom management, then I'm concerned that we're not addressing the core issue." P18 (male, 55–64)

Watchful waiting: Some participants preferred the phrase 'watchful waiting' as it implied a proactive approach from their clinician. It was interpreted as meaning close monitoring of symptoms, watching for improvement, and acting upon any changes.

"I think that's the most impactful of those five. It involves a proactive approach. But it's still telling you to wait." P10 (female, 45–54)

A few raised concerns that this phrase could inadvertently induce an unnecessary focus on symptoms if interpreted as the clinician anticipating possible negative outcomes.

"I might be a bit more nervous thinking they might think there's something there that needs looking into." P22 (female, 55–64)

Wait and see: A few participants preferred 'wait and see' for reasons similar to those expressed for watchful waiting. However, unlike watchful waiting, it did not elicit any potential concerns.

"Wait and see means for me that I'm going to put up with it and deal with it the best I can. Perhaps unless it escalated to a point that I would then have to go back and do some action." P12 (female, 55–64)

Do nothing: This was negatively perceived by most participants and interpreted as their concerns were being ignored, that the clinician lacked responsibility or expertise, or that they felt dismissed.

"If he tells me just do nothing, means that he's ignoring my problem" P25 (male, >65)

"It feels a bit irresponsible!" P04 (female, 45–54)

"I'd feel like I've just been left without any sort of wait and see, you know, without any support!"

No active treatment: This phrase was perceived by some as frightening and conveying hopelessness as nothing could be done to help.

"It just gives that impression that there's no hope on dealing with this. It's as if, like, just go and wait to die."

"… it's sort of a bit of a statement saying look, there's nothing doctors can do." P29 (male, 18–34)

3.2.4. *Individuals highly valued clear communication about a 'wait and see' approach and wanted a collaborative and action-oriented plan for the waiting period provided*

Many participants wanted clinicians to explicitly communicate that a 'wait and see' approach, when applicable, is a reasonable option for managing the condition.

"When they don't mention the option of wait and see, I, as a nonprofessional, I don't know there is other option of a wait and see." P04 (female, 45–54)

When this option is presented, most participants wanted it to be accompanied by clear information such as the course and likely duration of the illness with and without treatment. If the 'wait and see' option was decided upon, participants wanted a collaboratively devised plan that included information such as how to self-monitor and self-manage symptoms while waiting and what symptoms or timeframe should trigger a re-consultation.

"You can't just tell them [patients]to wait and see and just leave it vague." P02 (female, 35–44)

"I just want the full facts, like I said, so I could make a decision about what's best for me." P15 (female, 45–54)

"I would also like to have a wait and see plan. Like things that I can take back like what am I going to wait and see for and then how long until I see them again" P09 (female, 18–34)

"I would like to know what the advantages and disadvantages of that are" P12 (female, 55–64)

Some participants mentioned that having written and/or visual information provided to help explain and retain this information would be helpful.

"I could picture it and remember it whereas everything that GP says verbally, I might not remember everything," P01 (male, 18–34)

"English is not everyone's first language, so visuals help" P09 (female, 18–34)

Some participants highlighted the importance of clinicians considering individual circumstances when offering this option and being empathetic.

"So, in determining the wait and see, I think they need to understand that I've already done five things before I've got there. So, I think he's looking at me as a whole individual not as just that condition in general." P10 (female, 45–54)

"If you give them a little bit more empathy, I guess, of their situation and say, Okay, I'm going to take care of you and make a plan." P09 (female 18–34)

4. Discussion and conclusion

4.1. *Discussion*

Our findings provide insight into the varied interpretations of a 'wait and see' approach for self-limiting illnesses. Factors that influenced the acceptability of this approach included the relationship with their clinician, familiarity with the condition, symptom severity and duration, and individuals' responsibilities. When considering various phrases to describe the approach, 'symptom management' was the most preferred and 'do nothing' was the least preferred and perceived negatively. Most participants expressed a desire for clinicians to discuss a 'wait and see' option when it is safe and appropriate, but when this occurs, for there to be a transparent and collaborative deliberation about this option and it to be accompanied by an action plan.

A strength of our study is the diversity of age groups, gender, and educational levels. However, a limitation is that most participants spoke English as their first language. It remains unclear how non-native English speakers might perceive the 'wait and see' approach. Also, the majority of our participants indicated a preference for a more passive, rather than aggressive, approach to healthcare on the single-item question asked, with possible implications for how accepting they were of a wait and see approach.

Previous research on individuals' perspectives of a 'wait and see' approach is limited, primarily focusing on cancer screening, testing, and treatment. Some of our findings align with a qualitative systematic review by Rittenmeyer et al. [20], which highlighted factors influencing individuals' decision to pursue a watchful waiting approach for cancer treatment. One factor that contributed to the reluctance of this approach was a lack of sufficient information and support by clinicians during consultations, particularly regarding prognosis. Their participants desired more information and guidance to assist them in making informed decisions, as did participants in our study. Another finding that aligned with our study's findings was the pressure individuals felt to opt for active treatment to seek a quick fix [20].

Consumer Reports (a network of consumer organisations which aim to empower informed decisions) and Choosing Wisely highlighted in a review of the literature about communicating 'what not to do' to consumers [21] that messaging aimed at discouraging behaviours should provide clear instructions on alternative courses of action. Participants in our study emphasised the importance of receiving clear communication about how to monitor the progression of their health issue and having a well-defined plan of action for situations such as if symptoms worsened. The same review also highlighted the influence of trust in clinicians on consumer acceptance of messaging. Our study found that participants indicated greater acceptance of a 'wait and see' approach when a trusted clinician suggested it.

In a recent qualitative study of Australian GPs about their perspectives on using natural history information in decision-making about antibiotics for self-limiting infections [22], GPs reported that patients often lack awareness that many infections resolve without antibiotics

and that when they communicate to patients about the likely self-resolving course of the -illness, it is often to justify not prescribing antibiotics as patients were expecting. This aligns with our observation that patients often are not aware of the nature of self-limiting conditions. In a study that examined the ability of individuals with low health literacy and/or poor English skills to read and understand two shared decision-making support tools [23], the phrase 'wait and watch' was identified as difficult to comprehend, regardless of whether English was their native language. Some of their participants interpreted 'wait and watch' to mean sitting in the waiting room prior to a consultation or waiting to find out about test results and were confused to learn it is a potential illness management option.

4.2. Conclusion

The phrase 'wait and see' was interpreted in a few ways. Individuals were generally accepting of a 'wait and see' approach for some self-resolving illnesses, although less so for some illnesses and in some circumstances. They wanted it at least presented as an option when appropriate, with 'symptom management' as the preferred terminology. Clear communication and collaborative decision-making were valued, and if the option to wait was chosen, then participants wanted to feel supported and be given a plan for the waiting period.

4.3. Practice implications

When 'wait and see' is a reasonable option, clinicians should explicitly present it as such to patients and provide relevant information to help patients make an informed choice. If this option is chosen, then collaboratively establishing a plan for the waiting period is important. Clinicians sometimes use patient decision aids to facilitate shared decision-making with patients. Ideally, aids should contain information about all the available options, including, where appropriate, the option of 'wait and see' and the benefits and harms of the options. However, some aids do not explicitly include this option and/or quantitative information about it [24]. If clinicians use patient decision aids for self-limiting illnesses, they should check if the aids contain this information. Reflecting on which terminology to use when describing this option verbally and when it is included in decision aids is also important. The standards that guide the development of patient decision aids (International Patient Decision Aid Standards) are currently being updated [25]. Findings from this study could be used to guide the wording about presenting information about options in decision aids in a balanced way [26].

Further research is needed about wording preferences in more diverse populations, including those with low health literacy and languages other than English. Also needed is research into perspectives of this approach for other conditions, such as chronic conditions or those where the decision is between having or not having surgery.

Ethics application

This study received ethics approval from the Bond University Human Research Ethics Committee (BUHREC),

Consent

Informed consents were obtained before the commencement of interviews.

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CRediT authorship contribution statement

Hoffmann Tammy C: Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization. **Bakhit Mina:** Writing – review & editing, Supervision, Formal analysis. **Abukmail Eman:** Writing – review & editing, Writing – original draft, Visualization, Validation, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.pec.2023.108032.

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