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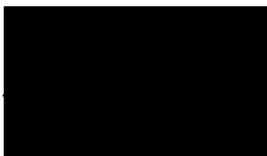
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**A CONTRIBUTION TO THE  
UNDERSTANDING OF  
HEALTHCARE  
RELATIONSHIPS IN LONG  
TERM HEALTH CONDITIONS**

Hannah Pooley

**A thesis submitted in partial fulfilment for the degree of Doctor of  
Clinical Psychology**

**Coventry University, Faculty of Health and Life Sciences  
and the University of Warwick, Department of Psychology**

**May 2013**

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- NHS Research and Development, UHCW Trust

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- IPA analysis guidance
- Annotated transcript
- Table of themes with supporting quotes

## LIST OF ABBREVIATIONS

ADD	American Diabetes Association
A&E	Accident and Emergency
AMED	Allied and Complementary Medicine Database
ARF	Acute Renal Failure
CI	Confidence Interval
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CKD	Chronic Kidney Disease
DOH	Department of Health
ESRF	End Stage Renal Failure
GP	General Practitioner
HbA1c	Glycated Haemoglobin
IPA	Interpretative Phenomenological Analysis
WHO	World Health Organization
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
OR	Odds Ratio
SIGN	Scottish Intercollegiate Guidelines Network
UK	United Kingdom
US	United States
SD	Standard Deviation

*N.B.: The terms 'chronic illness', 'long term health condition' and 'chronic disease' have been used interchangeably throughout this thesis.*

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Finally I would like to show gratitude to the doctors who were willing to take time out of their working day to take part in this research and share their experiences with me.

## **DECLARATION**

This thesis was carried out under the supervision of Dr Adrian Neal and Dr Julie Highfield, with Dr Helen Liebling Kalifani acting as research co-ordinator. I collaborated with the supervision team to design the empirical study, to recruit participants and for feedback on drafts of chapters. Apart from these collaborations, this thesis is all my own work and has not been submitted for a degree at any other University. Authorship of papers arising from this work will be shared with the supervisors. A written summary of the findings will be sent to the participants who took part in the study.

## **SUMMARY OF CHAPTERS**

Chronic illnesses are the leading cause of death worldwide and are also expected to be the leading cause of disability by 2020 (World Health Organization [WHO], 2003). They are changing the experience of healthcare for both patients and healthcare professionals. In particular, they are changing the roles of patients and doctors, with patients expected to be more involved in their disease management and doctors shifting their focus away from curing pathology to regulating and palliating symptoms (May, 2005).

Chapter one presents a systematic review of the role of patients' relationship styles on healthcare outcomes in diabetes. Outcomes of the review highlight the impact of attachment styles that are characterised by having a 'negative model of other' on health outcomes. Despite methodological limitations, the review finds evidence to support the use of attachment theory for understanding healthcare outcomes in the diabetes population and describes the clinical utility of using attachment theory in the development of interventions with this patient group.

Chapter two examines the experiences of healthcare professionals in chronic illness in an empirical study investigating the lived experiences of the long term doctor-patient relationship in male Consultant Nephrologists. The experiences of seven Consultant Nephrologists were explored using a phenomenological approach. Findings revealed three superordinate themes: 'Defining my professional identity', 'Relating to the patient' and 'Coping with the job'. Clinical implications of the findings and recommendations for future research are discussed.

Chapter three continues the theme of healthcare relationships in a reflective paper based on a journal kept by the author throughout the research process. This paper considers the challenges of conducting psychological research in medical settings, in particular, the researcher's own initial reservations about these challenges and how the researcher feels now the study is complete. Such reflections may be beneficial for psychologists conducting future research in this area.

# **CHAPTER 1**

## **THE ROLE OF INSECURE ATTACHMENT IN ADULTS WITH DIABETES: A REVIEW OF THE LITERATURE**

This paper has been prepared for submission to the following journal:  
*Clinical Psychology Review*. In accordance with manuscript guidelines  
(Appendix A) numbering of sections of the review is not recommended by  
the journal but has been done for ease of reading.

Word Count: 7,986 (excluding tables and references)

## **1.0 ABSTRACT**

Diabetes is a serious chronic illness with a globally increasing prevalence. The complicated medical and lifestyle regimens crucial for the successful management of the disease imparts significant burden on both patients and healthcare systems alike. Attachment theory has been offered as a way of understanding a number of healthcare outcomes in patients with diabetes; however a systematic review of the research has not yet been conducted. Therefore, this review explores the relationship between insecure attachment and a number of healthcare outcomes in patients with diabetes. Despite the methodological limitations, there is evidence to suggest that patients with insecure attachment styles that have a negative internal working model of other have worse healthcare outcomes than those with secure attachment styles and insecure attachment styles with a positive model of other. As well as offering a theoretical understanding of these behaviours, attachment theory could have clinical implications for the development of interventions with this patient group to help improve healthcare outcomes.

**Keywords:** Adult attachment; Type 1 diabetes; Type 2 diabetes; Healthcare outcomes; Doctor-patient relationship

## **1.1 INTRODUCTION**

Diabetes is a serious chronic illness that significantly impacts on healthcare systems across the world (World Health Organization [WHO], 2006). The prevalence of diabetes in the United Kingdom is estimated to be 1.9 million and this number is expected to rise to 4 million people by 2025 (Diabetes UK, 2010). Diabetes is a global problem and by 2030 the worldwide prevalence is estimated to reach 439 million adults (Shaw, Sicree, & Zimmet, 2010).

Attachment theory is increasingly being used as a way to further our understanding of a range of healthcare behaviours such as adherence to medications, engagement with healthy lifestyle regimens and healthcare utilisation (Ciechanowski et al. 2004). Attachment theory has been theoretically linked to diabetes and could have a role in explaining a number of healthcare behaviours that are significant in the impact and management of diabetes, however a comprehensive review of the evidence in this field has not yet been presented. This review addresses this issue by summarising and critically evaluating the available literature.

### **1.1.2 Type 1 and type 2 diabetes**

Type 1 diabetes is rarer than type 2 diabetes with over 90% of people with diabetes in the UK suffering from type 2 diabetes (National Institute for Health and Clinical Excellence [NICE], 2008). In most cases type 1 diabetes is considered to be a progressive autoimmune disease that occurs as a consequence of the immune system attacking the pancreatic

beta cells which results in a lack of insulin production and hyperglycaemia (Alberti & Zimmet, 1998). Unlike type 2 diabetes, type 1 diabetes is normally diagnosed in childhood or adolescence and the aetiology of type 1 diabetes is often thought to be due to biological factors rather than lifestyle factors. Treatment focuses on the management of symptoms and glycaemic control achieved through medical treatment, insulin treatment, dietary management, exercise and weight management (Alberti & Zimmet, 2004).

In contrast to type 1 diabetes, type 2 diabetes is characterised by gradual onset and usually begins with insulin resistance where fat, muscle and liver cells do not metabolise insulin properly which leads to an increase in the level of glucose in the blood (NICE, 2008). Risk of developing type 2 diabetes increases with obesity and lack of physical activity (American Diabetes Association [ADA], 2012). There are also a number of biological risk factors such as older age, ethnicity and family history of diabetes (Moore et al., 2010). As in type 1 diabetes, treatment of type 2 diabetes often focuses on management through insulin therapy, healthy diet and exercise. In both types, if poorly managed the consequences are a number of serious health problems such as limb amputation, blindness, cerebrovascular disease, kidney failure and premature death (Kinder, Kamarck, Baum & Orchard, 2002). In people with diabetes the measure of glycated haemoglobin (HbA1c), a measure of glucose molecules in the blood, is an important component of diabetes management. If high (8% or above) it often indicates poorly controlled blood glucose levels and can

lead to a number of diabetic complications if untreated (Selvin et al., 2004). Additional information on both type 1 and type 2 diabetes can be found in Appendix C.

### **1.1.3 The psychological impact of diabetes**

Despite differences in classification, the management of both types of diabetes remain similar in their complexity and reliance on self-care. Diabetes is considered to be one of the most emotionally and behaviourally demanding of the chronic diseases (Cox & Gonder-Frederick, 1992) and Anderson (1985) suggests that 95% of the management of diabetes has to be conducted by the patient. Treatment is complex, with a pressure to meet physiological markers such as healthy glucose levels, lipid levels and blood pressure and also maintain a healthy lifestyle and optimum weight by eating a suitable diet, exercising regularly and following a complicated medical regimen that involves regular check-ups of HbA1c (Ciechanowski, Katon, Russo & Walker, 2001). This is further complicated by the serious long term health complications associated with diabetes (WHO, 2006). Consequently, a diagnosis of diabetes can have a significant impact upon quality of life (Rubin & Peyrot, 1999).

### **1.1.4 Attachment theory in adults**

Bowlby defined attachment as a 'lasting psychological connectedness between human beings' (Bowlby, 1969, p.194). He hypothesised that humans are biologically predisposed to form an attachment to a caregiver

to ensure their needs are met for their survival. Research suggests that attachment relationships are important throughout the lifespan (Ainsworth, 1982) and attachment styles are a relatively stable trait (Scharfe & Bartholomew, 1994).

### **1.1.5 Internal working models**

According to attachment theory it is not only the continuity of the relationship with the attachment figure that is important but also the quality of that relationship. Bowlby (1969) hypothesised that humans internalise their first relationship with a caregiver to form a prototype for other relationships they experience throughout life. This first relationship is referred to as a 'blueprint' in which 'internal working models' are developed. Internal working models can be thought of as cognitive schemas that explain how people view themselves and other people (Bowlby, 1980). Internal working models are thought to be influenced by two key things: whether or not the attachment figure tends to be the sort of person who responds to the child's calls for support and protection; and whether or not the self is judged to be the sort of person towards whom anyone, and in particular the attachment figure, is likely to respond to in a helpful way (Bowlby, 1980).

### **1.1.6 Attachment styles in adults**

Bartholomew and Horowitz (1991) developed a classification system for adult attachment styles including one secure style (secure attachment) and three insecure styles (dismissing, preoccupied and fearful). It is

believed that while adults may display different characteristics from each of the styles at different times, they tend to fit with one predominant attachment style (Ciechanowski, Walker, Katon, & Russo, 2002). Each attachment style is thought to have a different internal working model system and characteristics as summarised in Table 1.

*Table 1. Key characteristics of the four attachment styles*

<b>Attachment Style</b>	<b>Key Characteristics<sup>a</sup></b>
Secure	Comfortable with intimacy and autonomy. Positive internal model of self and others. Results from consistently responsive caregiving during childhood. Thought to have low levels of attachment anxiety and attachment avoidance.
Preoccupied	Preoccupied with relationships. Positive internal model of others and negative model of self. Often perceived as 'clingy'. Results from inconsistent caregiving during childhood. Thought to have high levels of attachment anxiety.
Dismissing	Dismissing of intimacy. Compulsively self-reliant. May struggle to depend on others. Positive internal model of self and negative model of others. Results from consistently unresponsive caregiving during childhood. Thought to have high levels of attachment avoidance.
Fearful	Fearful of intimacy, socially avoidant. Negative internal model of self and others. Results from rejecting or abusive caregiving during childhood. Thought to have high levels of attachment avoidance and anxiety.

<sup>a</sup>based on Bartholomew & Horowitz (1991)

### **1.1.7 Attachment and physical health**

Adult attachment styles are thought to impact upon interpersonal functioning and ability to collaborate at times of distress, such as in the presence of physical illness (Sullivan et al., 2009). There is also increasing evidence to suggest that the relationship between patient and healthcare professional has similar qualities to an attachment relationship (Adshead, 1998). Aspects of attachment relationships such as signalling distress, seeking proximity to the caregiver and using interpersonal contact to modify affect are all relevant in healthcare relationships (Maunder et al., 2006).

In addition internal working models, as previously discussed, are thought to impact upon whether the individual sees themselves as worthy of care and sees others as trustworthy and capable of providing care (Bowlby, 1969). Therefore, internal working models could have a significant impact on both the relationship between patient and healthcare professional (if the healthcare professional is seen as trustworthy of providing care) and on the way the patient carries out self-care (if they see themselves as worthy of care). In chronic illnesses such as diabetes, due to the complicated medical and lifestyle regimens and reliance on patient self-management, the patient-provider relationship is thought to be most effective when it is collaborative (Paterson, Thorne & Dewis, 2007). This style of relationship, which focuses on a partnership between patient and healthcare professional with an emphasis on shared decision making, has been shown to be associated with better health outcomes (Stewart, 1995).

Therefore, patients with an insecure attachment style who may struggle to accept care from others (negative model of other) and/or care for themselves (negative model of self) may find the complicated self-care and collaborative relationship required for effective diabetes management particularly challenging. As it is estimated that individuals with a secure attachment style account for just less than half of primary care patients with diabetes (Ciechanowski et al., 2004) this could present a significant challenge to healthcare services.

## **1.2 AIM OF REVIEW**

The focus of the current paper is to critically and systematically review research relating to the impact of insecure attachment in adults with diabetes. More specifically, the review aims to answer the following questions:

*Question 1: How does insecure attachment affect healthcare outcomes in adults with diabetes?*

For the purpose of this review, healthcare outcomes are defined as:

1. Health behaviours
2. Clinical outcomes
3. Engagement with services

*Question 2: With regards to insecure attachment and diabetes outcomes, what other factors are considered in the literature?*

*Question 3: What are the limitations of the current research base, clinical implications and directions for further research?*

## **1.3 METHOD**

### **1.3.1 Search strategy**

Literature searches were conducted between February 2013 and April 2013 using the following databases: Medline, PsycINFO, CINAHL and AMED. Search terms used were 'attachment' AND 'diabetes'. Figure 1 presents a map of the literature search.

### **1.3.2 Inclusion and exclusion criteria**

Inclusion criteria required articles:

- to be empirical peer-reviewed studies,
- to use a measure of adult attachment or relationship style,
- to measure a diabetes-related healthcare outcome,
- to use an adult population with type 1 or type 2 diabetes.

The review excluded papers that did not use an adult population, did not use a direct measure of adult attachment/relationship style and that had a quality assessment score in the 'low' category.

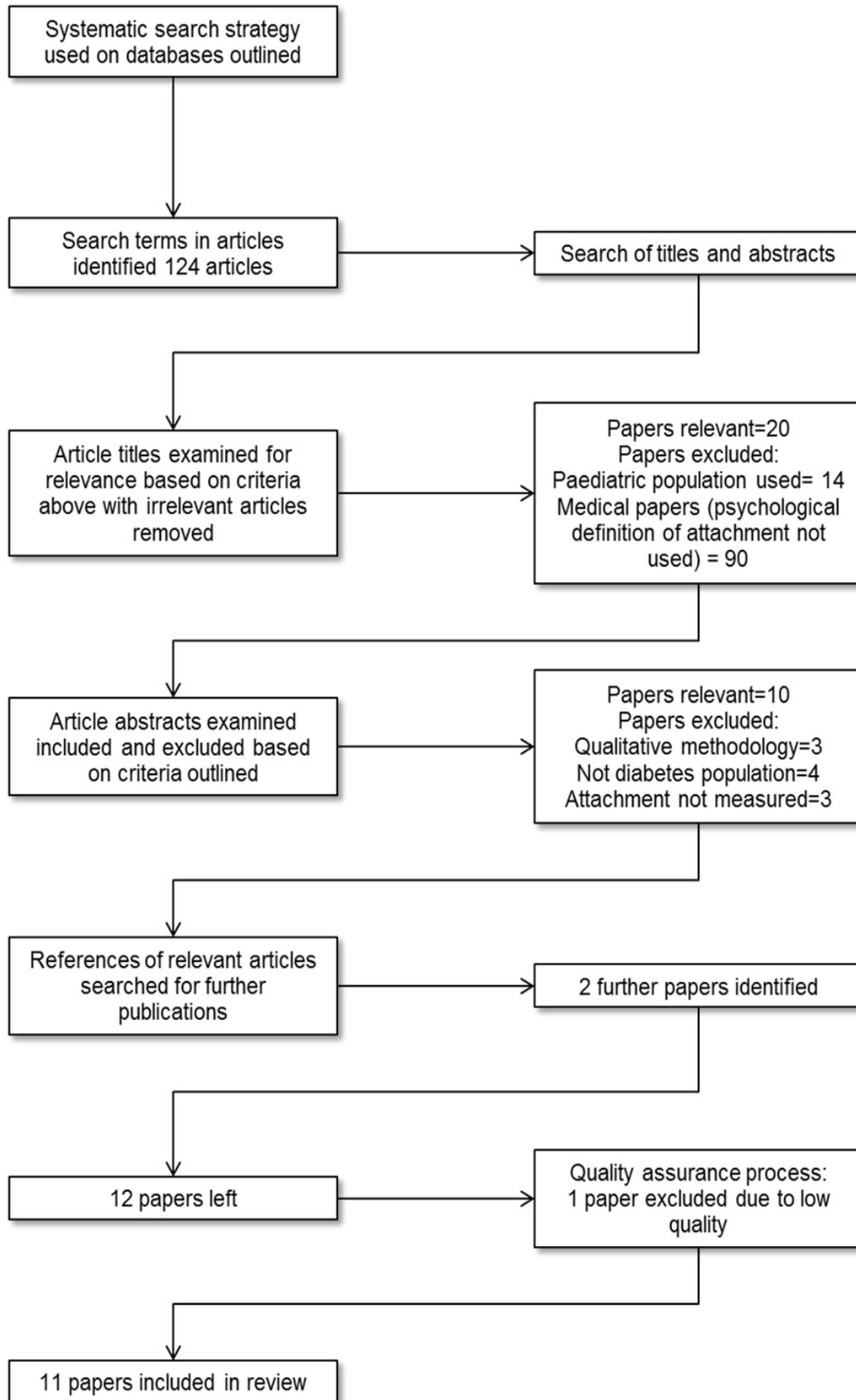


Figure 1. Literature review systematic search strategy

### **1.3.3 Preliminary synthesis of findings**

Of eleven papers identified for the review, eight papers were cross-sectional, two papers were longitudinal and one paper was a randomised controlled trial. Eight of the studies were conducted in North America, one was conducted in the United Kingdom, one was conducted in Turkey and one was conducted in Iran. From the cross-sectional studies, the majority of the samples were convenience samples and several of the studies conducted in America were conducted by the same research group recruiting participants from a national study (Katon et al., 2004). A detailed description of the studies meeting the inclusion criteria can be found in Appendix B.

### **1.3.4 Quality review**

Quality assessments are used to determine the quality threshold for the selection of studies for systematic reviews and to explore quality differences in study results. Accurate assessment of study quality is imperative in the synthesis of study findings in order to appropriately interpret results and effectively guide clinical care (Armijo-Olivo, Stiles, Hagen, Biondo & Cummings, 2012). Many of the quality assessment tools available evaluate the quality of randomised controlled trials and intervention studies, with fewer tools available for the systematic appraisal of non-intervention studies. Therefore, for the current study, a combination of available checklists was used with questions adapted to suit the study topic based on quality assessment criteria proposed by Scottish Intercollegiate Guidelines Network (SIGN) (2011). A copy of the

quality assessment tool used can be found in Appendix B. A quality assessment score for each paper included in the review can be found in Table 2. Papers were scored out of a possible maximum score of 27. Papers that scored  $\geq 75\%$  were deemed high quality, papers that scored between 50% and  $<75\%$  were deemed moderate quality and papers that scored  $<50\%$  were considered as low quality and were excluded from the study.

Table 2: Quality assessment scores

<b>Paper</b>	<b>Quality Assessment Score</b>	<b>Rating</b>
Ciechanowski, Hirsch & Katon (2002)	22	High quality
Ciechanowski et al. (2004)	21	High quality
Ciechanowski, Russo, Katon, Simon, et al. (2006)	21	High quality
Ciechanowski et al. (2001)	21	High quality
Morse, Ciechanowski, Katon & Hirsch (2006)	20	Moderate quality
Ciechanowski, Katon & Russo (2005)	20	Moderate quality
Morris et al. (2009)	20	Moderate quality
Ciechanowski, Russo, Katon, Von Korff, et al. (2006)	20	Moderate quality
Ciechanowski et al. (2010)	16	Moderate quality
Bazzazian & Besharat (2012)	15	Moderate quality
Turan, Osar, Turan, Ilkova & Damci (2003)	14	Moderate quality

## **1.4 REVIEW OF THE LITERATURE**

### **1.4.1 Question 1: How does insecure attachment affect healthcare outcomes in adults with diabetes?**

#### ***1.4.1.1 Insecure attachment and healthcare behaviours in diabetes***

Healthcare behaviours can be defined as any activity undertaken by a person to maintain, attain or regain good health and prevent disease such as adherence to medical regimens and self-directed health behaviours like following a healthy diet and exercising regularly (Conner & Norman, 1996). Healthcare utilisation can also be defined as a healthcare behaviour however for the purpose of this review this topic will be discussed in section 1.4.1.3. Healthcare behaviours such as maintaining a healthy lifestyle and adhering to a complicated medical regimen are important factors that impact on clinical outcomes in diabetes (Ciechanowski et al., 2001).

Insecure attachment has been associated with more harmful healthcare behaviours in diabetes. For example, Ciechanowski et al. (2004) found in a US sample (N=4095) with type 1 and type 2 diabetes that participants with fearful attachment style were less likely than participants with secure attachment style to exercise (odds ratio [OR]= 1.33, 95% confidence interval [CI]=1.03-1.71). Participants with a dismissing attachment style were significantly more likely to have lower levels of exercise (OR= 1.36, CI =1.13-1.62), foot care (OR=1.21, CI=1.02-1.45), healthy diet (OR=1.41

CI =1.17-1.69), adherence to oral hypoglycaemic medications (OR=1.23, CI= 1.01-1.51) and be a current smoker (OR=1.42, CI=1.08-1.86) compared to participants with a secure attachment style. Both of these attachment styles share the 'negative model of other' indicating that these individuals are likely to find it difficult to trust and rely on others either through compulsive self-reliance (dismissing attachment) or fear (fearful attachment). Therefore, it is possible that this could impact on their ability to carry out a range of healthcare behaviours as they may not acquire the guidance and support of healthcare professionals and family (Ciechanowski et al., 2004).

Although dismissing attachment style is characterised by a positive model of self the results suggest that these individuals are not engaging in self-care behaviours as well as some of the other attachment styles. In particular, behaviours that require involvement from others, such as diet and exercise, are worse in these individuals and this could be the result of the compulsive self-reliance distinctive of this attachment style. It has also been suggested that people with this attachment style could have the tendency to minimise or ignore distress (Fraley & Shaver, 1997) and a consequence of this may be difficulties in attuning to their needs and carrying out self-care behaviours (Ciechanowski et al., 2004). While the results of this study are compelling, it should be noted that only 192 of the 4095 participants had type 1 diabetes therefore the results of this study may not be representative of participants with type 1 diabetes. In addition, the use of pharmacy refill records to assess adherence to medications

may not be an accurate measure of whether participants actually took medications.

Turan et al. (2003) present further evidence of the relationship between fearful and dismissing attachment styles and poor adherence in their study exclusively focused on people with type 1 diabetes. The Relationship Scales Questionnaire (Griffin & Bartholomew, 1994) was used as a continuous measure of fearful and dismissing attachment in a Turkish sample (N=89). Higher dismissing attachment related to poorer adherence to blood tests ( $r(83) = -.23, p < .05$ ) and insulin injections ( $r(83) = -.22, p < .05$ ). Fearful attachment was also significantly associated with poorer injection adherence ( $r(83) = -.24, p < .05$ ). These results are interesting but a significant limitation of the study is that adherence was measured using a self-report measure and therefore could be prone to recall and social desirability biases. Also, the findings are restricted in their generalisability due to the relatively small convenience sample of Turkish participants with type 1 diabetes. In addition, the effect sizes of the statistically significant relationships between attachment measures and the two measures of adherence were relatively small indicating that other variables may have influenced the results found.

In addition, Morse et al. (2006) present evidence of poorer healthcare behaviours in insecure attachment in 714 participants with type 1 and type 2 diabetes. 9.7% (N=69) reported engaging in night-eating behaviours, an eating habit that can be particularly problematic for people

with diabetes, and compared to those without night-eating behaviours these participants were more likely to have an insecure attachment style. However the authors did not break 'insecure attachment' into categories and it was not clear why this was and no valid or reliable measure of night-eating syndrome was used to classify participants.

### *Summary*

Findings from the above studies, while having methodological limitations, suggest insecure attachment styles have a negative impact on diabetes-related healthcare behaviours. Dismissing attachment style has shown to have the most unhelpful healthcare behaviours in two of the studies and there have been a number of explanations using Bowlby's (1980) internal working models to help hypothesise why this may be. Interestingly, although the findings are limited to three studies, two of the studies produced similar results in very different populations, a US sample of both type 1 and type 2 diabetes and a Turkish sample of participants with just type 1 diabetes, suggesting that the impact of attachment style on diabetes health behaviours may be a pattern that is not restricted to more westernised countries.

#### ***1.4.1.2 Insecure attachment and clinical characteristics in diabetes***

Research suggests that the insecure attachment styles, in particular fearful and dismissing attachment, are associated with more harmful healthcare behaviours in diabetic patients. There is also evidence to

suggest that clinical characteristics of this group are worse compared to other attachment styles.

Ciechanowski et al. (2010) conducted a longitudinal study over 5 years to investigate the association between relationship style and mortality in diabetes. Participants were divided into two categories, independent or interactive relationship style, based on a median split on the Relationship Questionnaire (Griffin & Bartholomew, 1994). Those with an independent style were defined as being less likely to trust others and this is strongly associated with dismissing and fearful attachment styles while those with an interactive style are relatively comfortable relying upon others and this is strongly associated with secure attachment style (Ciechanowski et al., 2010). Of 3535 participants with type 1 and type 2 diabetes, rate of death in the interactive group was 29/1000 while in the independent group it was 39/1000. The unadjusted relative risk indicated that those in the independent group had a 33% increased risk of death and this was after controlling for other known risk factors of mortality. The adjusted relative risk gave a 20% increased risk of death for the independent group in comparison to those in the interactive group, however the model showed only modest significance ( $p < .05$ ).

The authors noted that there could be immunological differences between the different relationship styles as previously discussed in the research (Picardi et al., 2007). However, they also highlighted the problems with adherence, self-care and collaboration with healthcare professionals in

people with an independent relationship style and this may explain the results found. The limitations of this study include that it was based on part of a sample from a study previously discussed in this literature review (Ciechanowski et al., 2004) and the authors failed to provide any demographic details about the sample used. While the results of this study suggest a link between insecure attachment and mortality, the grouping together of attachment styles into 'independent' and 'interactive' limits the conclusions that can be drawn from the results and the ability to reliably compare the results with other attachment studies.

In addition to risk of mortality, several studies have reported findings on HbA1c with the advantage of having an objective clinical measure recorded in a patient's medical records. Once again, it is dismissing attachment style that appears to have worse outcomes. For example, Ciechanowski et al.(2001), in 367 participants in the US with type 1 (N=14) and type 2 (N=353) diabetes, found that participants with dismissing attachment style had significantly higher HbA1c levels (N=89, mean=7.99%, SD=1.49%) than participants with preoccupied (N=85, mean=7.38%, SD=1.23%), secure (N=106, mean=7.49%, SD=1.24%), and fearful attachment style (N=73, mean=7.47%, SD=1.32%)( $p=.05$ ). However, such results are limited in their generalisability as all participants had health insurance and therefore may have faced fewer socioeconomic barriers than the rest of the population. Further, the proportion of type 2 diabetes patients in this research was much larger than those with type 1 diabetes.

Further evidence in participants with type 1 diabetes comes from Ciechanowski et al. (2002) who obtained mean HbA1c levels over a year from 276 participants in the US with type 1 diabetes. Participants with fearful attachment style (N=52) had significantly higher mean HbA1c levels ( $8.1 \pm 1.5\%$ ) compared with participants with secure attachment (N=100) ( $7.5 \pm 1.1\%$ ) ( $p=.03$ ). The authors also reported a trend level difference in HbA1c levels between participants with dismissing attachment (N=55) ( $8.0 \pm 1.2\%$ ) ( $p=.01$ ) compared with those with secure attachment style. There was also a significant overall effect of the proportion of participants in each attachment style group with HbA1c levels  $\geq 8\%$  ( $\chi^2=10.4$ ,  $df=3$ ,  $p=.02$ ). Of these participants, 62% with dismissing attachment had HbA1c levels  $\geq 8\%$  compared with 34% of participants with secure attachment style ( $\chi^2=9.27$ ,  $df=1$ ,  $p=.002$ ) and 39% of participants with preoccupied attachment style ( $\chi^2=4.74$ ,  $df=1$ ,  $p=.003$ ). While 50% of the participants with fearful attachment style had HbA1c levels  $\geq 8\%$ , this did not differ significantly from the other three groups. A regression analysis found that after adjusting for age, income, marital status, depression, medical comorbidity and number of diabetes complications, participants with dismissing attachment style still remained significantly more likely to have HbA1c levels  $\geq 8\%$  than participants with secure attachment. In the same study, a correlation analysis found that HbA1c values were negatively correlated with secure attachment style ( $r(228)=-.17$ ,  $p<.01$ ) and positively correlated with dismissing ( $r(228)=.15$ ,  $p<.05$ ) and fearful attachment style ( $r(228)=.19$ ,  $p<.01$ ). HbA1c value

also had a significant correlation with 'model of other' ( $r(228) = -.16$ ,  $p < .01$ ) and overall attachment security ( $r(228) = -.21$ ,  $p < .01$ ), with more positive 'model of other' and attachment security negatively correlating with HbA1c level.

The authors hypothesised that both dismissing and fearful attachment styles are characterised by a 'negative model of other' which is likely to impact upon their ability to trust and rely on healthcare professionals. Therefore, this is likely to affect how much support these individuals can elicit and accept from healthcare professionals. Consequently, their engagement with the complicated medical and lifestyle regimen that is necessary for maintaining healthy HbA1c levels will suffer (Ciechanowski et al., 2002). While this study is limited in its generalisability as the sample were mainly white, educated up to at least first year of University, and all from a tertiary care health setting, the authors acknowledge how the results of this study are almost identical to that of a study carried out in primary care discussed previously in this review (Ciechanowski et al., 2001). In addition, this study provides important information in a sample of participants with type 1 diabetes, as this sample has been poorly represented in the literature so far.

While much of the literature has shown the negative impact of insecure attachment styles on HbA1c value, Ciechanowski et al. (2004), as discussed previously, found that participants with preoccupied attachment were significantly less likely to have HbA1c levels  $>8\%$  compared to

those with a secure attachment style ( $p < .05$ ). This result suggests that preoccupied attachment style may impact positively on healthcare behaviours that affect HbA1c levels. Research suggests that individuals with this attachment style may attend clinics more often, report more symptoms and their care-seeking attachment style may mean they are more likely to try and please healthcare professionals by maintaining optimum HbA1c levels (Ciechanowski et al., 2004).

### *Summary*

Insecure attachment styles have been shown throughout the research to be associated with worse clinical characteristics in diabetes. This evidence is particularly compelling as it provides a range of data and recurrent findings that insecure attachment styles with a 'negative model of other' are associated with worse clinical characteristics in both type 1 and type 2 diabetes populations. This includes both HbA1c levels and mortality. Interestingly, preoccupied attachment style, with its 'positive model of other' was the only attachment style to show favourable outcomes when compared to secure attachment on HbA1c, suggesting that this insecure attachment style could have a positive impact on disease management in diabetes.

#### ***1.4.1.3 Insecure attachment and engagement with healthcare services***

The research so far has demonstrated worse outcomes in diabetes patients with insecure attachment styles with a 'negative model of other'.

This section will consider if such results are extended into how this group engages with healthcare services.

### *Service utilisation*

In terms of utilising healthcare services, Ciechanowski, Russo, Katon, Simon, et al. (2006) conducted a study in the US with participants with type 1 and 2 diabetes (N=3923) investigating the association of attachment style and missed primary care appointments. Three types of appointment were looked at: scheduled office visits which represented planned care for symptom or illness driven reasons; same day visits which represented unplanned care for symptom or illness-driven issues that are not urgent enough for the accident and emergency department; and scheduled annual preventative care reviews.

In this study, dismissing and fearful attachment styles had more missed scheduled appointments compared to participants with a secure attachment style, and this was discussed in terms of these participants inability to rely on others due to being self-reliant or fearful (Ciechanowski, Russo, Katon, Simon, et al., 2006). In terms of booked appointments, participants with a fearful attachment style booked significantly more same day appointments but overall used services less compared to those with secure attachment. The authors discussed this in terms of the approach-avoidance behaviour distinctive of this attachment style as these individuals are often mistrusting and fearful of others. These participants may avoid appointments until an emergency arises

and they must see a health professional, which would explain the need for more same day appointments (Ciechanowski, Russo, Katon, Simon, et al., 2006).

In the same study, when compared to secure attachment style, preoccupied attachment style was associated with more scheduled and same day appointments. This could be due to increased somatic symptom reporting that is characteristic of this attachment style and the reliance on others, in this case health professionals, for self-esteem (Ciechanowski, Russo, Katon, Simon, et al., 2006). However, preoccupied attachment style was also associated with more missed same day appointments compared to secure attachment style. The authors suggested that individuals with preoccupied attachment may already utilise health services more frequently and when further overwhelmed may not find added clinic appointments helpful, leading to more missed same day appointments (Ciechanowski, Russo, Katon, Simon, et al., 2006), however this hypothesis needs further exploring. While this study reveals some interesting results it has methodological limitations. Most apparent is their attempt to measure depression over the past year using the Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer & Williams, 2001) which is designed to estimate depressive symptoms over the last two weeks.

*Engagement with healthcare professionals*

Morris et al. (2009) investigated attachment and alliance with healthcare professionals in a UK sample with type 1 and type 2 diabetes (N=48). Participants and their diabetes clinician completed a questionnaire to rate the participant's level of attachment avoidance and attachment anxiety. Attachment avoidance is thought to be higher in dismissing and fearful attachment styles while attachment anxiety is thought to be higher in preoccupied and fearful attachment styles (Fraley & Shaver, 2000).

Contrary to the authors' predictions, participants who rated themselves as avoidant did not show any correlation in how they rated their alliance with staff. In fact, it was the individuals who were rated as avoidant by staff who reported poorer relationships with staff ( $r=-0.29$ ,  $p<.05$ ). The authors concluded that it is possible that those with higher attachment avoidance are more likely to minimise expressions of distress and this could increase the likelihood of a positive bias in reporting the quality of the relationships (Morris et al., 2009). However, in addition to this being a small sample, participants were recruited by the staff member who also took part in the study. It is therefore possible that this methodological idiosyncrasy might have introduced an unaccounted for bias which influenced participants in their rating of alliance to staff.

Ciechanowski et al.(2004), as discussed previously, presents more compelling evidence in a US sample of participants with type 1 and type 2 diabetes (N=4095). The authors found that attachment style was

significantly associated with patient-provider relationship scores in a mediation analysis ( $F_{3, 3572} = 11.6, p < .0001$ ). Higher patient-provider scores were found among participants with secure attachment (4.99,  $SD = 1.53$ ), indicating greater patient-provider collaboration compared with participants with fearful (4.62,  $SD = 1.51, p < .001$ ) and dismissing (4.71,  $SD = 1.50, p < .001$ ) but not preoccupied attachment style (4.89,  $SD = 1.50, p = .30$ ). The authors concluded that the findings are consistent with characteristics of dismissing and fearful attachment styles as they may be likely to find social interactions less rewarding and to view others as unavailable or incapable of providing care (Ciechanowski et al., 2004). It is also possible that certain characteristic features of dismissing attachment such as compulsive self-reliance and tendency to minimise distress resulted in less involvement by the provider and this was reflected in the scores (Ciechanowski et al., 2004).

In addition, Ciechanowski, Russo, Katon, Von Korff, et al. (2006) found in a US sample of participants with type 1 and type 2 diabetes ( $N = 324$ ) that those with an independent relationship style (as previously discussed in this review in Ciechanowski et al., 2010) were significantly more likely to report poorer satisfaction with diabetes care and more negative perceptions of feeling understood, listened to and encouraged by their diabetes doctor than participants with an interactive relationship style. For these studies, research would benefit from investigating in more detail the relationships between these participants and their providers to see if

participants are all receiving the same quality of care and involvement by the provider.

*The patient-provider relationship as a mediator variable*

As well as certain insecure attachment styles showing less engagement with services, the patient-provider relationship in this group seems to be particularly important. Ciechanowksi et al. (2001) found that participants with dismissing attachment who also perceived the quality of communication with their provider as poor had higher HbA1c levels (mean=8.50%, SD=1.55%) than those who perceived their provider's communication as good (mean=7.49%, SD=1.33%) ( $F=4.43$ ,  $df=1$ , 76,  $p<.05$ ). There were no significant differences in HbA1c by communication quality in any of the other attachment styles. Aggregate communication scores for each of the 22 providers rated by participants in the study showed that providers for the dismissing/poor communication group were not perceived by their overall panel of diabetic participants as having poorer communication than any other providers. A small subgroup of participants ( $N=17$ ) were analysed who were treated with oral hypoglycemics and it was found that those who had dismissing attachment style and rated provider communication as poor had significantly poorer adherence to glucose monitoring and significantly more interruptions in treatment with oral hypoglycemics than the rest of the study participants. Therefore in this study, participants with a dismissing attachment style who rated their patient-provider relationship

as poor were more likely to be disengaged from their providers and less adherent to treatment as indicated by elevated HbA1c levels.

Further evidence to support the hypothesis that the quality of the patient-provider relationship is of significant importance in diabetes self-care in this particular group comes from Ciechanowski et al. (2004) who found that the relationship between dismissing attachment style and positive smoking status and poor adherence to diet, exercise, foot care, and oral hypoglycemic medications was mediated through the patient-provider relationship (with proportions mediated ranging from 0.07 for smoking to 0.22 for foot care). They also reported that the relationship between fearful attachment style and poor adherence to exercise was mediated through the patient-provider relationship (0.14) and the relationship between preoccupied attachment and lower likelihood of having HbA1C value of >8% was mediated through the patient-provider relationship but the proportion mediated was very small (0.01). The limitations of this study have been previously discussed in the section above.

### *Summary*

Engagement with healthcare services has been explored in terms of the utilisation of services and the patient-provider relationship. Once again it is the attachment styles of fearful and dismissing and participants rated by their provider as higher in avoidance (a typical feature of the fearful and dismissing attachment styles) that show less engagement with services, less collaboration, less satisfaction with their diabetes doctor

and less alliance in their relationships with diabetes clinicians. In addition to this, the patient-provider relationship appears to be an important variable in diabetes outcomes for dismissing attachment in which it acts as a mediator variable between both objective clinical measures of blood glucose levels and a number of diabetes-related health behaviours.

#### **1.4.2 Question 2: What other factors are considered in the literature?**

A number of studies may help shape our understanding of the results found in this review so far. The purpose of this section of the review is to discuss papers which may help to offer further evidence on why the insecure attachment styles of dismissing and fearful are associated with worse healthcare outcomes in patients with diabetes.

##### ***1.4.2.1 Adjustment and coping***

Turan et al. (2003) present findings to suggest that dismissing and fearful attachment are associated with poorer psychological adjustment and more maladaptive coping styles in type 1 diabetes. Dismissing attachment was significantly correlated with the adjustment style of 'lack of integration' ( $r(89)=.43, p<.001$ ) which is indicative of poorer psychological adjustment (Welch, 1994) and correlated significantly with the maladaptive coping styles of avoidance ( $r(89)=.35, p<.01$ ) and passive resignation ( $r(83)=.48, p<.001$ ). Avoidance was defined as distracting oneself or directing one's attention away from diabetes-related issues and this underpins previous research that has shown that

dismissing attachment is associated with high levels of avoidance (Fraley & Shaver, 2000). Passive resignation was described as perceiving oneself as helpless and hopeless in dealing with diabetes. Fearful attachment was also significantly associated with lack of integration ( $r(89)=.37, p<.001$ ) and passive resignation ( $r(89)=.48, p<.001$ ).

In the same study, a mediation analysis showed that the negative effect of dismissing attachment on blood test adherence and injection adherence was mediated by avoidance coping. Furthermore, the positive effect of dismissing attachment on lack of integration was mediated by passive resignation. Passive resignation was also found to be a significant mediator of the effect of fearful attachment on adherence to injections as well as on lack of integration. This highlights how the coping strategies adopted by people with the attachment styles of fearful and dismissing might interfere with optimum self-care behaviours in diabetes although the mechanisms underlying this may be different as highlighted by the mediation analysis.

Adjustment and attachment in diabetes was also explored by Bazzazian and Besharat (2012) in type 1 diabetes patients who were members of the Iranian Diabetes Society in Tehran aged between 18-30 (N=300). Similar to other studies, participants were classified as having secure, avoidant or ambivalent attachment. Avoidant attachment is associated with dismissing and fearful attachment style and ambivalent attachment is associated with preoccupied attachment (Bartholomew, 1990).

Interestingly, avoidant attachment style had a positive effect on illness perception ( $t=2.78$ ,  $p<.01$ ) and positive effects on task-oriented coping strategy ( $t=4.09$ ,  $p<.01$ ). These results do not correspond with the previous research showing dismissing and fearful attachment styles to be associated with more maladaptive coping strategies. However it is possible that the characteristics typical of dismissing attachment style such as less self-disclosure, higher sense of disease control and having a greater trust in oneself could explain this finding (Bazzazian & Besharat, 2012). Despite this result, similar to the previous study, individuals had less adjustment to their illness ( $t=-4.25$ ,  $p<.01$ ). The authors hypothesised that these individuals often minimise distress, disclose less and have more trust in themselves which would result in better illness perception and more task-oriented coping strategies. However this does not explain why such individuals have worse adjustment to their illness.

Ambivalent attachment style did not have a significant effect on illness perception, although these participants had worse illness perception and adjustment compared to the secure group. Unlike avoidant attachment, ambivalent attachment demonstrated a negative effect on task-oriented coping ( $t=-2.26$ ,  $p<.01$ ). The authors attributed this to previous research that has shown that ambivalent individuals depend on others, show greater distress and inability to respond to the demands of their illness, show inflexibility in emotion regulation, and use emotion-focused coping strategies (Bazzazian & Besharat, 2012).

The main limitation of this study is the very specific population sample which thus limits generalisability. Further, a measure of attachment was used which resulted in the 'avoidant' attachment group accounting for both fearful and dismissing attachment styles which ignores key differences in these attachment styles already highlighted in this review.

#### **1.4.2.2 *The impact of depression***

Ciechanowski et al. (2005) conducted secondary analysis of data from the original study previously discussed (Ciechanowski et al., 2001) in 367 participants with type 1 and 2 diabetes recruited from two primary care clinics in US. Measures were taken from participants at two stages ten months apart. They found a negative correlation between depressive symptoms and model of self (e.g. higher depression scores associated with anxiety and feeling unworthy in relationships) and other (e.g. higher depression scores associated with avoidance or low trust of others) with the association being greater for model of self. Participants that increased in levels of depression had significantly lower (more negative) model of self scores than the participants who had no change in depression at ten months. Thus, depression appeared to impact on both the participant's model of other and model of self. Therefore, this study shows that the symptoms of depression can present as similar to that of an insecure attachment style, and should be considered as a possible confounding variable when measuring attachment. A significant limitation of this study was the lack of control of other possible confounding variables such as use of antidepressants, psychotherapy or significant life circumstances.

### *Summary*

Results from studies on adjustment, coping and attachment in diabetes are mixed. It is unsurprising that research shows that fearful and dismissing attachment styles are associated with more maladaptive coping styles and less adjustment to diabetes. However other evidence reported more adaptive coping mechanisms and illness perception in avoidant attachment styles compared to ambivalent attachment, even though adjustment to illness was worse in the avoidant group. These findings, although restricted to type 1 diabetes population, present a confusing picture and could be indicative of one of the difficulties of working with this particular group as their tendency to minimise distress and disclose less may result in a bias towards positive self-report.

Furthermore, the finding that depression in diabetes is associated with similar characteristics to insecure attachment styles means that this could be an important confounding variable that needs to be considered when researching associations between insecure attachment and diabetes and designing interventions based on patients' attachment styles.

### **1.4.3 Question 3: What are the limitations of the current research base, clinical implications and directions for further research?**

#### ***1.4.3.1 Overall limitations of evidence base***

Most of the evidence in this area is based on cross-sectional research with the limitation that it provides only a 'snap shot' of the relationship

between attachment styles and diabetes-related variables and tells us little about causality. However, it could be argued that attachment style is a relatively stable trait (Hamilton, 2000) although research highlighting the change in attachment profiles of diabetes patients with depression adds complexity to this argument (Ciechanowski et al., 2005) and could highlight the potential pitfalls of relying too much on attachment theory. Most of the literature follows the assumptions that it is more likely that it is attachment style that is impacting on the diabetes variables, although we do not have empirical evidence to underpin this hypothesis and it is likely that this would be very difficult to demonstrate.

Attachment research is also limited by the inconsistencies in how attachment is conceptualised. Brennan, Clarke and Shaver (1998) attempted to rectify this problem by conducting a factor analysis of a number of attachment measures in order to come up with one concept. From their research they found that two common factors were apparent, attachment avoidance and attachment anxiety, and developed the Experiences in Close Relationship Scale which is considered to be the quality benchmark attachment measure (Mikulincer & Shaver, 2007). Despite this, none of the studies in this literature review used this measure.

Furthermore, it has been noted throughout this review that much of the research has been produced by the same research group using convenience samples in the US. Therefore, there is the possibility of

researcher bias due to the same research team conducting much of the research and it is likely that the evidence base would be strengthened with the addition of research from other research teams. Most of the research from this population is limited in its generalisability as samples were mainly white and educated with healthcare insurance. In addition, some of the research has used the same sample for a number of separate analyses, again restricting the generalisability of the findings and perhaps giving a misleading impression about the depth of the research base for this topic.

#### **1.4.3.2 Clinical implications**

Despite the methodological limitations of the studies in this review, there is evidence to suggest that it would be beneficial to be aware of a patient's attachment style as part of their diabetes care and tailor treatment accordingly. Patients who are non-adherent to diabetes treatment, miss appointments and show less collaboration in the patient-provider relationship are a source of great frustration to clinicians.

Attachment theory could be used as a developmental theory to help clinicians gain greater understanding of what otherwise may be viewed as 'difficult' patients and this may help to improve empathy and tolerance for such patients. The use of both quantitative and qualitative research is needed to show the outcomes of using this framework as a tool to help clinicians improve their understanding of their patients' interpersonal patterns and increase their empathy for this group.

The research suggests that patients with insecure attachment styles that have a 'negative model of other' are at particular risk of worse diabetes healthcare outcomes. Therefore, this patient group may require special measures to help manage their diabetes for better treatment outcomes. In particular, the patient-provider relationship appears to be of particular importance for diabetes outcomes in these patients, and could benefit from targeted interventions that are adapted to the patient's interpersonal style and increase the patient's feelings of control.

Evidence for the clinical utility of the research comes from a randomised controlled trial by Ciechanowski, Russo, Katon, Von Korff, et al. (2006) who conducted secondary analysis of results from a previous study (Katon et al., 2004) which focused on patient-centred care based on the participants' relationship styles at the level of the patient-provider relationship in participants with diabetes receiving treatment for depression. They hypothesised that compared with depressed participants with diabetes with an interactive relationship style, those with an independent relationship style would derive greater benefit from a 'collaborative care' intervention designed to proactively follow participants and adapt to their preferred mode of interaction (e.g. telephone or in person visits) (N=160) compared with usual care (N=164).

Of participants with an independent style, the participants receiving the intervention had more depression free days compared with participants receiving usual care ( $200 \pm 83.6$  vs  $152.6 \pm 83.4$ ,  $f_{2,187} = 14.79$ ,  $p = .0002$ ). In

the interactive group, there were no significant differences between intervention and usual care ( $169.7 \pm 82.2$  vs  $178.4 \pm 84.2$ ,  $f_{2,131} = .15$ ,  $p = .70$ ). There was also greater satisfaction with the collaborative care model compared to usual care during the first six months of treatment among participants with an independent style compared to interactive. Furthermore, those with an independent style received significantly more problem-solving treatment (a therapeutic intervention offered as an elective part of the collaborative care model) (34 vs 41  $p < .05$ ).

In this study, participants with an independent relationship style derived greater benefit from a collaborative care intervention for depression in diabetes compared with usual care. This resulted in more therapy visits, less depression severity and higher satisfaction with care in those with an independent relationship style but not those with an interactive relationship style. The differences in outcomes did not appear to result from difference in antidepressant use rates, antidepressant adherence or mental healthcare use. It is possible that participants with an interactive relationship style are at an advantage in interacting with providers and health teams (i.e. usual care) to get their needs met compared to those with an independent style. Therefore, the collaborative care component did not result in advantages over usual care for these participants. However, for participants with an independent style, proactive following up and treatment adapted to their preferred mode of interaction was likely to provide them with more chances for interacting on their terms (Ciechanowski, Russo, Katon, Von Korff, et al., 2006).

The results of this study are compelling as they provide evidence of how patient relationship styles may help to guide more effective healthcare for diabetes patients with depression. Although this intervention was targeted around depression care, it is possible that strategies that respect these patients' need for autonomy or fear of intimacy while enhancing their perceived sense of control in the healthcare setting were particularly rewarding for patients who struggle with relying on others (Ciechanowski, Russo, Katon, Von Korff, et al., 2006).

#### **1.4.3.3 Recommendations for future research**

Based on the findings of this review and the limitations highlighted, future research in this area would benefit from more longitudinal studies which may help us to glean more information about the relationship between insecure attachment and diabetes. In particular, more intervention studies are needed to help us further understand the impact of using the evidence found so far to tailor diabetes treatment and the impact this could have on diabetes outcomes. The 'collaborative care model' as proposed by Ciechanowski, Russo, Katon, Von Korff, et al. (2006) needs further exploration to disentangle which components of the model were particularly helpful for people with an independent relationship style and also to see if the results found in this depression study can be extended to other diabetes-related outcomes such as HbA1c levels.

Furthermore, much of the research has treated participants with type 1 and type 2 diabetes as a synonymous group. As already discussed in this review, while the diseases share some similarities such as the focus on patient self-management and the complicated medical and lifestyle regimens required for effective disease management, the aetiology of these two diseases are very different. Type 1 diabetes often develops in childhood when attachments to caregivers are still forming. Therefore the development of diabetes in childhood may impact on the quality of attachment to the caregiver. However, type 2 diabetes tends to develop in adulthood and the lifestyle factors that are thought to contribute to the development of type 2 diabetes such as poor diet and lack of exercise have been shown to be associated with more avoidant attachment patterns. Therefore, it may be that in type 2 diabetes attachment has an impact on the development of the diabetes. Future research may benefit from comparing the two diabetes types to establish if there are any differences between them in order to tailor interventions accordingly.

## **1.5 OVERALL CONCLUSION**

The aim of this review was to investigate the relationship between insecure attachment and healthcare outcomes in adults with diabetes. Whilst this is still a relatively undeveloped area of research, there is good evidence to suggest that insecure attachment styles that have a 'negative model of other' have worse diabetes outcomes. The recurrent finding that dismissing attachment style is the style in which the worst diabetes outcomes are associated with is compelling, however more intervention

based studies to demonstrate the clinical utility of this research are required. In addition a number of methodological limitations need to be resolved such as consistent use of the same attachment measure across the research to allow studies to be reliably compared, as well as further investigation into the differences between patients with type 1 and type 2 diabetes.

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# **CHAPTER 2**

## **THE LONG TERM DOCTOR-PATIENT RELATIONSHIP AS EXPERIENCED BY MALE CONSULTANT NEPHROLOGISTS**

This paper has been prepared for submission to the following journal: *British Journal of Psychology*. In accordance with manuscript guidelines (Appendix

A) the correspondence address will be added to the title page prior to submission and tables will be moved to the end of the paper.

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## **2.0 ABSTRACT**

Research exploring the views and perspectives of Consultant Nephrologists on their experiences of the long term doctor-patient relationship is lacking. By adopting a qualitative approach this paper reports on the first known study exploring the lived experience of the long term doctor-patient relationship in Consultant Nephrologists. Seven male Consultant Nephrologists took part in semi-structured interviews and the data was analysed using Interpretative Phenomenological Analysis (IPA). Three superordinate themes were identified from the analysis: 'Defining my professional identity', 'Relating to the patient' and 'Coping with the job'. Themes are discussed in light of the current research base and clinical implications and research recommendations are highlighted.

**Keywords:** Doctor-patient relationship; Chronic illness; Nephrology; Phenomenological.

## **2.1 INTRODUCTION**

### **2.1.1 An introduction to the changing dynamic of the doctor-patient relationship**

The unique relationship between a doctor and their patient has been the subject of philosophical, sociological and psychological research and is recognised as the foundation of care (Dorr Goold & Lipkin, 1999). It is the milieu in which data is gathered, diagnoses and plans are made, adherence is achieved and healing and support are provided (Dorr Goold & Lipkin, 1999; Lipkin, Putnam & Lazare, 1995). Research has shown that improvement in the relationship results in greater compliance with treatment regimens (Ettinger & Freeman, 1981) and that the relationship could be used as a therapeutic tool in itself (Balint, 1957).

The doctor-patient dynamic has changed with advances in medical research and greater awareness of its importance in patient care. The very nature of care in the NHS and the relationship between NHS staff and patients has been the focus of a recent public enquiry which has highlighted the need to refocus healthcare professionals on the important factors in healthcare: patient-centered care delivered with compassion by committed staff (Francis, 2013). Models of care between the doctor and patient have developed from a paternalistic approach where the doctor is the expert who provides patients with advice and instructions about their health, to an increasing emphasis on shared decision making models where the relationship between doctor and patient is more equal (Edwards & Elwyn, 2009). In addition, current research

has focused on the use of attachment theory (Bowlby, 1973) as a framework in which to understand the doctor-patient relationship with the focus on the impact of the patient's attachment style on the way they engage in healthcare relationships and healthcare behaviours (Ciechanowski, 2010).

Furthermore, the increasing prevalence of chronic illness is changing the nature of the doctor-patient relationship. Chronic illnesses are the leading cause of death worldwide and are also expected to be the leading cause of disability by 2020 (World Health Organization [WHO], 2003). Previous research on the doctor-patient relationship has emphasised the doctor's role in treating organic pathology (Sinclair, 1997). However this focus may be unhelpful in chronic illnesses where solutions to on-going pathologies may be unavailable and the doctor's role as an individual who can cure sick patients is obsolete.

May et al. (2004) argues that in the context of chronic illness the central focus needs to take a wider account of a set of conditions and problems at the centre of which is the patient's own subjective experience of illness. Therefore, a model of collaborative care has been suggested to best manage chronic illness in which a patient-centred approach is adopted (Von Korff, Glasgow & Sharpe, 2002). Within this model, the need to attend to the emotional aspects of the patient's illness is acknowledged (Turner & Kelly, 2000) adding a different dimension to the doctor's role. This has been the topic of research in primary care where a model of 'Continuity of Care' has been suggested with patient and doctor forming a 'personal' relationship

(Forrest & Starfield, 1998). Within this model, it is believed that both parties benefit, with compliance improving when the patients feel that they 'know the doctor well' (Howie et al., 1999) and the clinical decision making process facilitated when the doctor feels they have good previous knowledge of their patient (Hjortdahl, 1992). Both patients and doctors report the value of such relationships (Kearley, Freeman & Heath, 2001).

Therefore, while the continued rise of chronic illness is changing the experience of illness for patients, it is also likely to bring significant changes to the experiences of healthcare professionals. The focus of medicine in this field is now centred on gauging, managing and palliating symptoms often resulting in minimal improvements in conditions where patients rarely recover and often decline (May, 2005). Doctors treating patients with chronic illnesses may feel disempowered and lose their ability to intervene in a way they perceive to be meaningful (Chew-Graham, May & Roland, 2004). Campbell & McGauley (2005) hypothesised that in chronic illnesses complex pathology may decrease the doctor's sense of effectiveness which can impact on their relationships with patients. Therefore, the emphasis falls upon the doctor's capacity to shift from a model of curing disease to a model of coping with disease. Roberts (2004) argues that it is this shift away from biomedical goals towards valuing the contribution that doctors can make to patients' management of their illness, as well as the success that can be found in the long term therapeutic doctor-patient relationship, which are crucial to a doctor's feelings of value.

### **2.1.2 The doctor's perception of working with patients with chronic illnesses**

Within the literature, patients with chronic illnesses are often referred to as 'heartsink' patients who have difficult relationships with doctors (O'Dowd, 1998). Research on doctors' experiences of the relationship has tended to focus on the perspectives of General Practitioners (GPs) due to the increasing support for the importance of doctor-patient relationships in primary care (Roberts, 2004). To the author's knowledge, no studies have looked at the doctor's perspective of the doctor-patient relationship in Nephrology. However the relationship between a GP and the patient can often be similar to those that are developed between a Nephrologist and the patient in terms of longevity, frequency of appointments and management of chronic illness and comorbid conditions. Therefore, the qualitative literature on GPs' experiences of long term doctor-patient relationships may be useful when considering the experience of Consultant Nephrologists.

For example, Cocksedge and May (2005) explored GPs' (N=28) constructs of long term relationships with patients and reported a theme of 'pastoral care' which was described as 'supportive care that is indirectly concerned with clinical medicine'. 'Holding' work was also referred to as a technique to manage patients with chronic illnesses and such relationships were described in terms of support rather than cure. However the authors reported disagreements between participants as to whether this was an effective use of their time.

In addition, Cocksedge, Greenfield, Nugent & Chew-Graham (2011) found in their study of GPs (N=11) that long term relationships with patients were described as 'holding' relationships and seen as a routine and significant part of their work. Participants described 'containing' the patient as an effective management strategy both in terms of preventing the progression of disease and reducing their use of secondary care resources. In such relationships, they talked about the importance of understanding that little clinical achievement was a positive outcome. All the participants valued offering on going 'holding' relationships to patients with several of them attributing job satisfaction and interest to these relationships. In addition, participants perceived value from providing emotional and social support, reassurance and hearing the patients' stories. Negative aspects were described as potential dependency from patients in long term relationships and worry about missing new clinical symptoms in chronic illnesses. Participants also highlighted the need for good interpersonal skills over medical expertise in these relationships.

However not all research has revealed positive experiences of the long term relationship in primary care. In a focus group study (N=54) Oldroyd et al.(2003) found that while rewarding aspects of chronic care such as getting to know the patient better were highlighted, the majority of GPs described chronic illness management as much more complex than acute care and some described it as 'chaotic' and 'a burden'. Goals of treatment were also described as hard to define making it less satisfying than acute care. They also spoke about the difficulty of juggling a number of roles in the doctor-

patient relationship such as advocate, patient support and evidenced-based clinician.

Similarly, Chew-Graham and May (1999) conducted a qualitative study of GPs (N=20) experience of relationships with patients with chronic lower back pain in primary care. They found that participants felt pessimistic about the chances of offering any therapeutic gain to patients in their consultations and worried whether the relationship offered a way of colluding with the patients illness behaviour. In addition, in a similar study Wileman, May and Chew-Graham (2002) interviewed GPs (N=15) about their experiences of relationships with patients with chronic medically unexplained symptoms in primary care. Analysis revealed that participants felt that these patients presented problems of control and authority in the consultation and this had a negative impact on the doctor-patient relationship.

It should be noted that both of these studies were focused on patients with particular types of chronic illnesses often with no clear medical pathology related to them. As a result, the opinions expressed by GPs in these studies may be more likely to be more negative than those supporting people with other types of chronic illness such as kidney disease or diabetes.

### **2.1.3 The role of the Consultant Nephrologist**

The role of the Consultant Nephrologist involves treating a mixture of acute and chronic patients: inpatients with acute renal problems that require urgent treatment such as Acute Renal Failure (ARF) and outpatients with Chronic Kidney Disease (CKD) who live in the community and may require

haemodialysis. Some patients will require a kidney transplant, which is also done under the care of their Nephrologist. Even after transplantation, the patient will still remain under the care of the Nephrologist. Ultimately, this means long term relationships between the patient and doctor in which the patient is not usually discharged and the relationship ends when the patient dies.

Many kidney diseases require commitment from patients to stick to vigorous medical and lifestyle regimens in addition to the management of comorbid chronic illnesses such as diabetes or hypertension (Curtin et al., 2008). Therefore difficulties and complications are inevitable and can test the strength of the doctor-patient relationship (Swartz, Perry, Brown, Swartz & Vinokur, 2008). In particular, in End Stage Renal Disease (ESRD) patients must undergo life sustaining dialysis therapy and interact with staff up to three times a week essentially for the rest of their lives (Swartz & Perry, 1999). Additional information on CKD can be found in Appendix C.

During the long term relationships with patients, while the basic medical commitment to patients requires clinical skills to promote patients' physical health, it also needs to encompass many non-technical, non-intellectual characteristics such as empathy, humour, patient-centred interactions, and basic caring and commitment to the person (Swartz & Perry, 1999). Therefore, in Nephrology the doctor is required to develop long term relationships with patients whom they will often see on a frequent basis and

may necessitate much more from them than just their clinical skills of diagnosis and treating.

#### **2.1.4 Summary and aims of current research**

The research on the doctor's experience of the long term doctor-patient relationship has tended to focus on the experience of GPs, presenting mixed findings in terms of how GPs view their long term interactions with patients. Research has highlighted that the prevalence of chronic illness is growing; in particular the prevalence of risk factors for the development of CKD such as diabetes, obesity and hypertension are growing at a rapid rate (Department of Health:[DOH], 2005). Patients who enter Renal Services are likely to remain in that service for the duration of their life placing great importance on the relationships they develop with their doctor. The patient's experience of the doctor-patient relationship in chronic illnesses has been explored extensively throughout the literature, however, relatively little focus has been given to the doctor's experience leading to a gap in our understanding of this complicated dynamic. A better understanding of the experience of the doctor is important because it has implications for medical training and service organisation and is particularly significant in light of current developments and proposed changes to the NHS as outlined by the public enquiry discussed previously (Francis, 2013).

Therefore, the aim of this study is to explore Consultant Nephrologists' experiences of the long term doctor-patient relationship. It is hoped that the findings of this study will help to improve understanding of the impact of long

term doctor-patient relationships on doctors given the nature of chronic illness.

The specific areas of interest were:

- Their most challenging and rewarding experiences in the long term doctor-patient relationship.
- The impact these experiences had on them.
- The possible coping strategies utilised in their work.
- Their reflections on their role in the long term doctor-patient relationship.
- The possible influential factors that have impacted on the way they act in doctor-patient relationships.

## **2.2 METHODOLOGY**

### **2.2.1 Design**

The lack of research in this area meant that developing an understanding of individual and shared perspectives was important. Interpretative Phenomenological Analysis (IPA) places emphasis on ideography, highlighting the importance of knowledge drawn from the individual's experience (Smith, Flowers & Larkin, 2009), seeks to capture the meaning and common features of experience (Starks & Trinidad, 2007) and explore complex aspects of experience that are not easily quantifiable (Barker, Pistrang & Elliott, 2002). It focuses on the in-depth exploration of the individual's lived experience, what the experience means to the individual and how the individual makes sense of that experience (Smith et al., 2009).

In addition to this, a 'double hermeneutic' is thought to occur during the analysis in which "The researcher is making sense of the participant who is making sense of x" (Smith et al., 2009, p35).

### **2.2.2 Participants and recruitment**

To be included in this research, participants were required to be a Consultant Nephrologist in the Renal Department selected for the study. They were also required to speak and understand fluent English.

A total of ten potential participants were identified at the initial recruitment stage and seven male participants agreed to take part. For IPA studies, it is recommended that between 6 to 8 participants allows for sufficient depth in analysis whilst capturing breadth of experience across a sample (Smith et al., 2009). The mean age of the participants was 48 years old with a range from 36 to 58 years. The mean length of time as a consultant was 11 years with a range from 1 to 23 years. For the purpose of anonymity, the names of participants has been changed and ethnicity has remained confidential.

### **2.2.3 Semi-structured interview**

Semi-structured interviews were conducted to allow participants the opportunity to give detailed accounts of their experiences in their own words. The use of semi-structured interviews is thought to be one of the most widely used tools in qualitative research and is recommended for use with IPA methodology (Smith et al., 2009). A semi-structured interview schedule was developed based on guidelines produced by Smith et al. (2009) and can be

found in Appendix D. The aim of the interview schedule was to explore participants' experiences of the long term doctor-patient relationship as a Consultant Nephrologist with a focus on letting the participant guide the direction the interview went.

The interview schedule was appraised by the research team prior to the study starting. In addition, a Clinical Psychologist who worked in the Renal Department also reviewed the schedule and made suggestions about how to adapt the interview such as beginning with very broad questions (e.g. Can you tell me about why you decided to go into medicine generally?) to more specific questions about the doctor-patient relationship later in the schedule (e.g. Can you tell me about your most difficult experience in the doctor-patient relationship?) to help build rapport between the interviewer and participant.

## **2.2.4 Procedure**

### **2.2.4.1 Recruitment**

Each potential participant was initially emailed by the team Clinical Psychologist with an information sheet about the study (Appendix E) and consent form (Appendix E). The author also attended a department meeting to present the research idea to the potential participants. Anyone who wished to take part in the study was asked to email the author. Once an email was received from a participant stating that they would like to take part in the study the author contacted them via email or telephone to arrange a time to meet to conduct the interview.

#### **2.2.4.2 Ethical approval**

Ethical approval was granted from Coventry University (Appendix F), and University Hospitals Coventry and Warwickshire NHS Trust Research and Development Department (Appendix F).

#### **2.2.4.3 Interview procedure**

The interviews were conducted by the lead researcher between July 2012 and October 2012. Six of the participants were interviewed in a private clinical room at the hospital and one participant requested that the interview be conducted in his office at the hospital. Interviews lasted between 33 and 81 minutes (average length 55 minutes). All participants were interviewed alone.

When participants arrived for the interview they were given the opportunity to ask any questions and were asked to read through the information sheet and consent form. If they were still happy to take part in the study, written consent was requested. In addition, the participants were reminded that the interviews would be recorded and transcribed verbatim and that any potentially identifying information would be removed from the transcripts. At the end of the interview, participants were once again offered the opportunity to ask any questions and de-brief with the interviewer.

## **2.3 DATA ANALYSIS**

### **2.3.1 IPA methodology**

Transcripts were analysed using the qualitative methodology of IPA (Smith et al., 2009). Interviews were transcribed verbatim and any identifying information was removed. The data was analysed based on the approach by Smith et al. (2009). See Appendix G for an explanation of this process, a section of coded transcript and a list of super/subordinate themes with associated transcript quotes.

### **2.3.2 Quality assurance**

Elliot, Fisher and Rennie (1999) provide guidelines on assuring quality in qualitative research such as owning one's own perspective, situating the sample, grounding in examples and providing credibility checks. These guidelines were followed throughout the study to provide a measure of quality assurance. For example, to ensure the reliability of analysis, as suggested by Elliott et al. (1999), members of the research team who also were experienced researchers reviewed the preliminary lists of codes and themes to ensure the themes were coherent and transparent.

In addition, the analysis kept closely to the original transcripts and the original transcripts were constantly referred to throughout coding. This was enhanced by providing a table of themes and corresponding supporting quotes found in the interview transcripts (See Appendix G). Also, another suitably trained professional with experience of qualitative research methods

who was not part of the research team reviewed one of the transcripts to ensure that the themes were not limited to the viewpoint of the lead researcher (Smith et al., 2009).

The importance of reflexivity in IPA has also been emphasised by Smith et al. (2009) as threats to validity and reliability are hypothesised to arise from the researcher themselves. Therefore, an essential part of quality assurance is the process of reflexivity throughout the research to enable critical self-awareness. To augment this process, the lead researcher kept a reflective journal during the research process and this was used to further enhance analysis. Furthermore, after each interview the researcher listened back to the recording to ensure that they were not asking leading questions or being too directive during the interviews. Regular meetings with the research team to reflect on the interviews during this process also helped the researcher to be mindful of their own position and thoughts and feelings about each interview.

### **2.3.3 Position of the researcher**

At the time of the interviews taking place, the author was employed as a Trainee Clinical Psychologist by a local NHS trust. During the research process the author was particularly influenced by models of adult attachment styles and their impact upon healthcare relationships (Bartholomew & Horowitz, 1991) and the work of Michael Balint detailing the powerful therapeutic effect of doctors as people (Balint, 1957). The researcher made notes of their expectations at the beginning of the study in a reflective journal

and anticipated that it may be difficult to engage doctors within psychological research. In addition the researcher recognised that she had previous experiences of working alongside medical consultants in a physical health setting and this may also impact upon the results found.

## **2.4 RESULTS**

### **2.4.1 Overview of superordinate themes**

In accordance with guidelines provided by Smith (2011) all superordinate themes were evidenced in interviews of all the participants and each subordinate theme was discussed by at least half of the participants.

Supporting quotes are included in the text with the line numbers in brackets.

Superordinate and subordinate themes are shown in Table 3 (evidencing quotes can be found in Appendix G).

*Table 3: Table of superordinate and subordinate themes across all participants*

<b>Superordinate Themes</b>	<b>Subthemes</b>
Theme 1: Defining my professional identity	More than a medic Comparisons to other specialties Liking the long term relationship I need more than just the chronic work
Theme 2: Relating to the patient	The patient is a person Finding empathy Being a patient has helped The trust between us Patient affection is important
Theme 3: Coping with the job	Emotional detachment Positive reframing

## **2.4.2 Superordinate theme 1: Defining my professional identity**

### **2.4.2.1 *More than a medic***

All participants discussed their identity in terms of more than a medical doctor who cures pathology: this included seeing their role as being about public relations (Alan, 376-377); as salesmen (Philip, 151-152) and as advocates (Christopher, 778). Emphasis was given to the value of non-medical aspects of their identity, for example, below Brian describes how medicine has changed for him, as instead of curing he finds value in reassuring patients and giving them confidence:

Brian: It's become much more to do with communicating and helping people and having people feel better about their disease and about themselves and where they are. I think we do just as much good by reassuring people that life goes on and there will be problems and we can generally find a technical solution but to actually have them feeling good about that and using my knowledge and understanding to give them a little bit of confidence about what's going on. (42-49)

In addition, Richard describes his identity as a healer rather than a medic:

Richard: ...and my interests now are much more to do with healing. Not healing in terms of making people better because Nephrology you have probably learnt by

now is not a specialty where we cure many people, but healing in terms of giving patients a prognosis and some hope. (21-32)

#### **2.4.2.2 Comparisons to other specialties**

It seemed as a way of defining their identity participants compared Nephrology to other medical specialties both in terms of similarities and differences. A number of participants described their role as similar to a GP. For example, Philip described how the longevity of the relationships he has with his patients are similar to that of GP-patient relationships, but also describes how he will be 'looking after someone' in a similar way to a GP rather than treating a patient as a hospital doctor would do suggesting he feels the similarities with GPs goes further than just the length of the relationships they develop with patients:

Philip: Something that you have in common with GPs you know you are going to be looking after someone for the rest of your career unless they move out of your patch so you get the relationship. (110-113)

Most of the comparisons with other specialties were around the longevity of the relationships with patients and this was sometimes discussed in a competitive manner in which medical specialties which did not have long term relationships were discussed as if they not as satisfying as George describes:

George: So if you look at a surgical speciality for instance although it's very technical and has got some satisfaction in it you see a patient that comes in with a problem you cut them open stitch them up send them away and never see them again probably so that hasn't got the chronic part of it. (37-42)

#### ***2.4.2.3 Liking the long term relationship***

All participants discussed how they enjoyed the longevity of the relationships they had with patients. For some this was because it was helpful in diagnosing and treating patients (Alan, 78-84) however for others, the long term relationship appeared to be about more than a simple medical association. For example, Christopher describes how he enjoys the fact that patients will be under his care forever:

Christopher: So they are not just acute and sick and complicated they are also patients who once they head to the renal services they tend to be there forever because once you get an established renal failure or advanced chronic kidney disease you either end up in the clinics forever or on dialysis. And even if they get a kidney transplant they stay in services. So you stay with the patients forever. And I really like that aspect of it, the

chronicity of the patient under your care who then stays under your care forever. (82-88)

Similarly, Michael describes how the long term relationship allows him to follow his patient's journey and see them progress in life:

Michael: ...as I say some of the people one's more friendly with, which I like, you know going through and getting married and having families, a series of jobs. So you get to hear a bit more about that. (348-351)

#### ***2.4.2.4 I need more than just the chronic work***

Although participants discussed the importance of long term relationships with patients as part of their professional identity, the majority of participants also discussed the attractions of acute work, with many of them indicating that this was the most rewarding part of their job. Below George describes how curing a patient and making them better immediately is the most rewarding part of his role:

George: Er the most rewarding aspect is when you see a patient who is almost dying and you treat them and the next day they are sitting up looking at you and smiling and saying thank you. There's nothing that beats that. (240-243)

Christopher goes further and describes how the acute aspect of his role is something he needs:

Christopher: Whereas if you've got somebody who's come in and is acutely unwell and you can make them better in the next two days, you see that result right in front of you and its quite a rewarding and satisfying thing to go home at the end of the day and think actually I made a bit of a difference coming into hospital today. Erm, I think that's er I think I er (pause) find that I quite need in my work. (115-122)

In addition, the fact that Nephrology offers a mixture of both chronic and acute work was often described by the majority of the participants as one of its main attractions. For example, Philip describes how he appreciates the mixture of acute and chronic work as it keeps his interest:

Philip : Yeah there's a big variety of different things and I like it because you're not you know we do different things you are on call and that's very busy and then we do clinics and things like that so there is a variety of things and that keeps you, keeps it very interesting. (96-100)

## **2.4.3 Superordinate theme 2: Relating to the patient**

### ***2.4.3.1 The patient is a person***

Most participants discussed the importance of considering the person behind the patient. However the reasons for this varied. Some participants seemed to want to know their patients as people, for example as George describes:

George: I think I mean I would have some inkling of how the patient thinks and how the patient I try to get into people's heads but I do that out of work as well that's how I am. So I try to get into people's heads and see how they are as human beings but it might be difficult in the first instance but over a period of time you get to know them. (350-356)

Other participants seemed to take a more detached position on getting to know their patient and discussed it in terms of improving compliance or the doctor-patient relationship. For example, Philip discussed how he tries to find things out about his patients, but again this seemed to be more about improving the doctor-patient relationship than genuinely wanting to understand the person behind the patient:

Philip: I usually try and find out something about the person you know they might like their garden, they might like this, so with some of the patients you can talk to about that so you just get so they can sort of get a feel,

they feel there is something there that they are not coming to meet a faceless person who just sits there in inverted commas 'in a white coat' and says do this do that do the other. So you have got a bit of something there that you can talk about as opposed to just the condition. (193-201)

#### **2.4.3.2 Finding empathy**

Empathy for the patient was discussed by some participants. However empathy was discussed in different ways. For example, empathy seemed to help some of the participants cope with frustrations in the doctor-patient relationship such as non-compliance as George describes:

George: Well I try not to, I'm not judgmental as far as patients are concerned so I don't make judgments about what they do. I try to, I try to empathise so if I know there are certain patients who smoke despite the fact that they shouldn't be smoking erm I know there are patients who erm don't take their tablets despite the fact that they you tell them to take their tablets and it's very frustrating because they they actually lie to you and they tell you erm you know they're not doing it and I try to empathise with them and I try to genuinely to say what would it be like if I was in their position. (289-291)

George's use of the phrase 'try to empathise' was reflected in other participants' descriptions of empathy as it was acknowledged that it was not something that came easily to doctors. For example, Richard highlights the differences in social class between doctors and some patients which make empathy more difficult:

Richard: ...its sometimes difficult you know most of us come from very posh upper middle class background so we don't naturally understand or empathise with you know the proletariat and er but we can learn and you can be better at it as well. (377-383)

#### **2.4.3.3 *Being a patient has helped***

Most participants described how the experience of being a patient or having a close family member be a patient has helped their doctor-patient relationships. This ranged from helping them to develop empathy for the patient (Michael, 464-473) to understanding feeling vulnerable (Brian, 1248-1251). For example, Alan described how it helped him to see things from the patient's perspective:

Alan: ...I've just been unwell and just come back working for last couple of months and I think on occasions I do, maybe it's a bit early since I've had this problem but I do kind of now see how a patient, so I sometimes now see in the position of a patient, and look inwards, outwards,

however you want to look at it, how would I be when I'm a patient and how are doctors treating me now... (408-414)

For some, it was having bad experiences of healthcare that had helped them to think about what it is like to be a patient. For example, Richard describes what it is like to be on the patient's side when a doctor makes a mistake:

Richard: First of all there was, one of the doctors with my leg made an error, fortunately it wasn't too bad we delayed the operation by 24 hours I mean I needed urgent surgery and this guy missed it so it made me realise doctors make mistakes if you make a mistake somebody can lose a leg or die I mean I knew that from my own as a kidney doctor but it was quite helpful to be on the other end of it and you know what a bummer if you died unnecessarily because of a doctor's mistake so it made me more patient-centered particularly as a consultant when you carry the can, you know, the final responsibility. (929-939)

#### **2.4.3.4 *The trust between us***

Trust between the doctor and patient was discussed by the majority of participants. There was some disagreement amongst participants about how trust is developed, with some discussing earning the trust of patients (Philip,

158-168) where as others believe patients instinctually trust doctors (George 132-140). Trust was discussed most often in terms of the patient trusting the doctor and was often described as a useful tool in treating patients rather than in terms of a bond between the doctor and patient, as Philip describes:

Philip: ...if you don't sell yourself then people won't trust you and if they don't trust you then they won't follow what you are saying and that's that. And that's the important thing in building a relationship because that is about the confidence and the patient says well I don't know what he's talking about but I trust him and that's the important thing and that's that. (150-154)

Richard expressed a similar opinion and describes how a patient's trust is an important part of the doctor's 'power' and suggests that trust can help with treating patients:

Richard: I think it's more important that you can communicate with patients and explain problems and get their trust and when they trust you, you've got 50% of your power as I said earlier 50% of what we do is placebo so if they don't like you or don't trust you or they don't like you because they don't trust you then you are just chopping off half your power erm so it just makes you a more ineffective doctor. (171-178)

Participants also discussed their trust for the patient, which was given less importance than the patient trusting them. Differences occurred in what participants felt impacted upon their trust of patients, with some discussing the impact of complaints on the doctor-patient relationship (Richard, 427-444), and others the impact of non-compliance (Christopher, 267-280). Ultimately, participants gave much greater importance to the patients trusting them than to them trusting the patient.

#### ***2.4.3.5 Patient affection is important***

Most participants described how they valued being thought of with affection by their patients. For example, Brian describes how he wants his patients to think of him affectionately:

Brian: So yeah I mean you shouldn't, we shouldn't underestimate how much I like to be liked, respected and valued and er and for people to think of me with affection you know I value that. (895-899)

Some participants spoke about the affection they received from patients, either through patients not wanting to be discharged (Philip, 606-609), wanting to stay longer during consultations (George, 402-412) or showing concern for their welfare as Alan discusses below:

Alan: ...I mean I was away for about 4 months and the patients who have come to see me when I was not there and they say '*Oh where have you been?*' and '*We've heard you have not been very well*' and '*I'm glad that you are back*' and without exception, even today I've had a patient who was very very complimentary... (164-170)

#### **2.4.4 Superordinate theme 3: Coping with the job**

##### ***2.4.4.1 Emotional detachment***

Emotional detachment was evident during the majority of the interviews. Some participants discussed how they actively used this strategy to cope with the job, and how it was an adaptive way of protecting themselves as George describes:

George: ...it's a survival instinct and you protect yourself and stop thinking about it otherwise we burn out. (218-232)

George's use of the word 'survival' adds emphasis to the importance he attributes to being able to detach from his work, indicating that without it he would not be able to survive as a doctor. In addition, Alan describes how he does not become emotionally attached to his patients using the phrase 'you have to be out of this circle of emotionally attached to them' again indicating the necessity of this coping strategy:

Alan: ...and then also those patients who you have known for a very long time and a lot of these patients over the years have died especially the young ones I just find it difficult, difficult to see how you know how such a young person would die. But again I think you have to be really out of this circle of emotionally attached to them and I think, I don't think I have ever been too much emotionally involved with any of our my patients to carry it the next day. (246-253)

#### **2.4.4.2 Positive reframing**

Participants appeared to use positive reframing to cope with the more challenging aspects of being a doctor. This is demonstrated in the quote from Christopher in which he describes the issue of breaking bad news to patients but identifies it as a rewarding part of the job:

Christopher: So yeah I think the hardest times are the sort of breaking bad news scenarios but I don't think they're, I don't think that's a problem with the doctor-patient relationship at all and if anything can strengthen it and if anything even though it's a hard thing to do, again its quite a rewarding part of the job as well because it's something that is very hard to do well and I think if you come away thinking that parted bad news but in a good way that can be quite a rewarding feeling. (669-677)

In particular, mistakes or scenarios where patients had died were often discussed in positive terms by focusing on the learning that could be achieved from them to enable better care for future patients. Below Brian describes learning from mistakes as a 'consolation':

Brian: Things do go badly, we don't always get it right but if we can salvage a good learning point for others to apply to the rest, you know then that experience may have worked beneficially for the next twenty or thirty or forty years anyway. That's a small price to pay for one patient to suffer, unintentionally, if in fact a learning point is made for over a thirty or forty year career. So you often get a consolation when things have gone badly about what you rescue from that. (553-561)

## **2.5 DISCUSSION**

### **2.5.1 Summary of the findings**

Three superordinate themes were common across all participants: 'Defining my professional identity', 'Relating to the patient' and 'Coping with the job'. Within the first theme, participants appeared to define their identity by expressing that their role involved more than providing medical treatment. However they also compared themselves to other specialities, suggesting that it was somewhat of a struggle to articulate their own identity. On the one

hand, participants described the positives of the long term doctor-patient relationship. However, all participants expressed the need for acute medicine and this seemed to be a strong and important part of their professional identity.

Within the superordinate theme 'Relating to the patient' participants described how they try to see past the disease profile of patients, although the reasons behind this varied, with some adopting this attitude as a way to improve compliance and others genuinely wanting to know their patients as people. Participants also discussed empathising with the patient although difficulties of this were highlighted by some. Participants also reflected on how being a patient had helped them relate to the patient and increased their empathy. In addition, trust between the patient and participant was discussed and while participants agreed that having a patient's trust was important they disagreed about how trust develops in the relationship. Finally, within this superordinate theme participants also described how they valued being liked by patients, and how this appeared to be an important part of their relationships with some patients.

'Coping with the job' was the last superordinate theme and came from accounts by participants of how they cope with their job as doctors. Two coping strategies were identified, 'Emotional detachment' and 'Positive reframing', both of which are strategies that avoid the affective part of experience. In particular, positive reframing was seen throughout participants' accounts of difficult experiences they have had such as

mistakes they had made and patients that had died which were discussed in terms of good learning opportunities or the benefit that could have come from them.

## **2.5.2 Discussion of the findings in relation to the literature**

### ***2.5.2.1 'Defining my professional identity' and the current literature***

Within this theme a number of challenges in defining their identity as Consultant Nephrologists were evident in participants' accounts. This was reflected in the subtheme 'More than a medical doctor' in which the doctors discussed how their role with patients was more to do with healing and providing reassurance than curing disease. Participants all spoke favourably about the long term relationship in the theme 'Liking the long term relationship' which is underpinned by research showing that desire for longitudinal interpersonal relationships with patients impacts on medical specialty choice (Fincher, Lewis & Rogers, 1992). Within the subtheme 'Liking the long term relationship', participants discussed the value of having longitudinal relationships with patients. However, this contrasted with the subtheme of 'I need more than just the chronic work' in which participants discussed how much they value acute medicine and curing sick patients. Traditionally, doctors have been thought of as those who cure pathology and research suggests that most medical students want to become doctors to cure patients (Lloyd-Williams & Dogra, 2004) and find acute and curable illnesses more attractive (Simpson, 1993). This could present a difficulty for participants in defining their identity and purpose as doctors, as the majority of their role involves managing chronic illnesses that are unlikely to improve.

These subthemes may highlight the conflict in identity that participants experienced, oscillating between their role as specialists in management of long term illness (Liking the long-term relationship) on one hand and then reacting to acute emergencies on the other (I need more than just the chronic work).

Further uncertainty in defining identity was evident in the subtheme 'Comparisons to other specialties' where participants appeared to try and define themselves by comparison to other medics. Social Comparison Theory (Festinger, 1954) states that individuals evaluate their own opinions and abilities by comparing themselves to others in order to reduce uncertainty in these domains and learn how to define the self. Within the literature there is disagreement about the identity of doctors ranging from 'advocates', 'healers' and 'humanistic physicians' (Novack, Epstein & Paulsen, 1999) to 'clinical scientists' (Medical Schools Council, 2009). Skills such as integrity, respect and compassion are often highlighted in the literature and clinical guidelines as important aspects of patient care however they are not routinely taught in medical school, giving a mixed message about the role the doctor is supposed to take. Research shows that these humanistic components of doctors' identities can actually decline during medical training (Hojat et al., 2009) indicating a conflict between what is expected of doctors and what occurs in clinical practice.

### **2.5.2.2 'Relating to the patient' and the current literature**

Within this theme participants discussed different ways that they relate to the patient. Empathising with the patient was discussed in most of the participants' accounts and was described as a helpful way in relating to the patient. This is supported by research that suggests that empathy can enhance both patient and doctor satisfaction (Kim, Kaplowitz & Johnston, 2004; Suchman, Roter, Green & Lipkin, 1993) and the therapeutic potential of the doctor-patient relationship (Suchman & Matthews, 1988). However empathy was often described as something the doctors would try to do rather than being an instinctual part of relating to the patient.

Literature has identified a number of barriers to empathy in doctors such as lack of time (Halpern, 2003), lack of importance given to empathy (Greenberg, Ochsenschlager, O'Donnell, Mastruserio & Cohen, 1999), cynicism (Testerman, Morton, Loo, Worthley & Lamberton, 1996), increased likelihood of burnout (Larson & Yao, 2005) and lack of training on compassion and psychological aspects of healthcare (Clark, 2001). Empathy is thought to incorporate cognitive, affective and behavioural processes (Irving & Dickson, 2004) and Newton, Barber, Clardy, Cleveland and O'Sullivan (2008) highlight how in some doctors empathy is 'role played' rather than actually experienced and there could be a number of reasons for this. For example, in this study it is likely that the coping strategies discussed by participants are not conducive to empathising with the patient as they tend to draw focus away from the affective part of experience.

Participants also described seeing their patients as people as a useful way of relating to them, which is key to person-centred care in Nephrology (NICE, 2009). Seeing the patient holistically was described by many of the participants however participants varied in their belief in this idea with some describing it a positive side of their job, whereas others seemed to take a more detached stance, in which getting to know their patient was a useful way to develop the relationship and ultimately improve compliance. This is supported by research suggesting that attitudes toward patient-centredness differ, with some doctors valuing it as the desired way of communicating with patients, while others see it as a means to varied ends (Lewin, Skea, Entwistle, Zwarenstein & Dicks, 2001).

The majority of participants highlighted the value of their own experiences as patients in their relationship with patients. In many cases these experiences led to increased empathy and this has been supported by other studies where doctors being patients had led to an increased sense of empathy and connection with the patient and had positive impacts on the way they practise (Fox et al., 2009). However much of the research on doctors as patients has focused on the challenges faced by doctors who become patients such as embarrassment (Davidson & Schattner, 2003), discomfort in the patient role (McKevitt & Morgan, 1997) or seeing their illness as 'trivial' (Shadbolt, 2003). Support for this was not found in this study.

Trust between doctors and patients was discussed in the subtheme 'The trust between us'. Trust was discussed in terms of being the foundation of

the doctor-patient relationship and as a useful tool to aid patient compliance. Evidence has shown that trust impacts on patients' willingness to seek care, reveal sensitive information and comply with treatments (Hall, Dugan, Zhang & Mishra, 2001; Rhodes & Strain, 2000). It is particularly important in chronic illness for improving adherence to lifestyle regimens (Mckinstry, Ashcroft, Car, Freeman & Sheikh, 2008) and this was highlighted by some participants in this study. Interestingly, some participants discussed 'earning' trust, suggesting that they believe patients can be mistrustful of them as doctors. This is supported by research showing that public trust in doctors is declining (Pearson & Raeke, 2000). Less importance was given on the doctor's trust of their patients and it has been suggested that this could be a defence against emotional closeness to the patient (Rogers, 2002).

Finally, participants discussed the value of patients liking them and thinking of them with affection in the subtheme 'Patient affection is important'. There is research to suggest within longitudinal doctor-patient relationships there are opportunities for 'personal' doctor-patient relationships to develop and such relationships are valued by GPs (Kearley et al., 2001). This idea was reflected within this subtheme in which participants spoke about patients' positive regard for them and interest in them. Literature suggests that doctor-patient relationships can be therapeutic for the patient (Di Blasi, Harkness, Ernst, Georgiou & Kleijnen, 2001) but evidence from this study suggests that they may be valued by the doctor as well. Suchman and Matthews (1988) argue that doctors seek meaning and purpose in life which can be found in the connections they make with patients. The doctor-patient relationship

provides an opportunity for doctors to feel attention and authority, and on occasion, release the everyday burdens of life and death situations they frequently face (Suchman & Matthews, 1988). What doctor, they contend, has not at one time been comforted by their patient?

### **2.5.2.3 'Coping with the job' and the current literature**

Much of the focus in the research on coping strategies in healthcare staff has focused on acute medicine such as A&E staff (Gillespie & Melby, 2003). However in Nephrology, most patients will remain under the care of their Nephrologist until they die, usually from an illness related to their CKD, which is likely to have a psychological impact on the doctors. In addition, the switching of Nephrologist's roles from managing long term chronic outpatients to dealing with acute medical may present a further challenge in how best to cope with such a varied role.

Two coping strategies were identified from participants' accounts: 'Emotional detachment' and 'Positive reframing'. The coping strategy of 'Emotional detachment' is supported by existing literature emphasising that detachment is a strategy used by doctors to cope with their own emotional reactions (Fallowfield, 1993). This has also been termed 'detached concern' in the literature and is described as 'not being moved or influenced emotionally by the patient' (Halpern, 2001). Emotional detachment has been suggested as a protection from burnout (Halpern, 2001) and this was supported by some of the participants' accounts in which it was described as an adaptive coping strategy which helps them to handle the situations they face as doctors.

The use of positive reframing in doctors has also received support in the literature. For example, McPherson, Hale, Richardson and Obholzer (2003) found positive reframing was a strategy used by A&E medics and was related to lower scores on the General Health Questionnaire suggesting it was an adaptive coping strategy. In this study, positive reframing was discussed most often when things had gone badly with patients, such as when the doctor made mistakes or the patient died unnecessarily. Literature suggests that medical errors can cause intense emotional reactions in doctors (Schwappach & Boluarte, 2009) and this coping strategy which focuses on solutions and the cognitive aspects of experience may be one way of managing such reactions.

### **2.5.3 Clinical Implications**

In the current study, participants' struggles with identity make clear some of the challenges for medics who specialise in chronic illness. Within chronic illness, there are fewer possibilities to cure patients on a regular basis, but this is something that participants valued greatly as part of their professional identity. For many, it was the acute scenarios of diagnosis and cure that were reflected upon as the most rewarding parts of their job. Medical training may need to give adequate attention to the doctor's role in chronic illness and give equal importance to the doctor's contribution in chronic specialties as to doctors who specialise in acute medicine. There is also a need to change focus away from curing towards building therapeutic 'personal' relationships with patients and the potential healing benefits of this in chronic

illness. This is likely to result in doctors feeling more valued and having increased job satisfaction and has already shown benefits in primary care (Forrest & Starfield, 1998).

The suggestion above creates a dilemma. In this study, participants valued long term relationships and the affection they felt from patients however they reported using coping strategies that involved an element of detachment from their job and their patients. Therefore, it is unlikely that they will be able to derive the full benefits of the 'personal' doctor-patient relationship.

Participants suggested that detachment was a protection from burning out and there is some evidence to support this idea (Huggard, 2003). However there is also research to suggest that denying the affective component of experience can have a detrimental impact on physical and mental health (Wastell, 2002). Medical professionals have higher rates of substance misuse (Bennett & O'Donovan, 2001) and mental health problems (Tyseen & Vaglum, 2002) than the general population and this highlights the importance of focusing on the psychological well-being of this group. Therefore coping strategies such as these need to be re-evaluated and up to date education underpinned by the latest evidence on adaptive coping and building resilience provided to doctors throughout their training.

In addition, an acknowledgement of the importance of the psychological well-being of doctors from the start of medical training in which an emphasis is placed on self-care is likely to be helpful. Increasing levels of support for doctors, reflective practice groups and training to increase coping strategies

and resilience are likely to help doctors become more mindful of their emotional responses to their job and feel more empowered to manage these without the fear of burning out.

#### **2.5.4 Limitations and directions for future research**

There are limitations to consider in this study such as the possibility for the high risk of variance in the interpretation of themes emerging from the data. To help manage potential bias, guidance on quality assurance in qualitative research was followed (Elliott et al., 1999; Barker et al., 2002) and transparency throughout the research decision making process and the position of the researcher has been declared and discussed as suggested by Smith et al. (2009). In addition, the interviews were conducted by a female researcher, which may have impacted upon the content of the interviews in that the male participants did not bring up certain topics because of gender differences. In addition the participants, while all male Consultant Nephrologists, differed in terms of age, ethnicity and length of time practising as a Consultant. Therefore future research may want to include a more homogenous sample to increase the depth of information gathered. Future research may also focus on the views of female Consultant Nephrologists to draw on any similarities or differences.

Further, the idea that some people provide self-defensive accounts of their experiences through the way they choose to see it (Holloway & Jefferson, 2000) could be particularly relevant in this cohort of male professionals as

they may have been reluctant to discuss experiences that they perceived to show signs of weakness of vulnerability.

## **2.6 SUMMARY AND CONCLUSION**

Despite the increasing prevalence of chronic illness there is a lack of research on the doctor's experience of long term doctor-patient relationships outside primary care. This paper contributes to addressing this issue by presenting the lived experience of male Consultant Nephrologists. For this group, the experience of the long term doctor-patient relationship encompasses 'Defining my identity', 'Relating to the patient' and 'Coping with the job'. Struggles in defining identity seemed particularly relevant for these participants and they appeared to be caught between the traditional idea of a doctor who cures pathology and the more modern notion of a doctor who specialises in the management of chronic illness whilst developing long term relationships with patients requiring much more than just their technical expertise. This was reflected throughout the other themes in which the participants on one hand valued patient affection and the long term relationship, but on the other hand used coping strategies that helped them remain detached from their job. Ultimately, this creates a confused identity for the doctor, and may also impact on the patient in terms of meaningful doctor-patient relationships and getting the full therapeutic benefit from this. Greater awareness of the psychological impact of being a doctor, up to date education on developing resilience and coping strategies and increased support for doctors in the work place may all be useful in helping with the issues raised by this research.

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**CHAPTER 3**

**REFLECTIONS ON THE CHALLENGES OF  
CONDUCTING PSYCHOLOGICAL RESEARCH  
IN A MEDICAL SETTING**

This paper has been prepared for submission to the following journal: *Clinical Psychology Forum*. Manuscript guidelines can be found in Appendix A.

Word Count (including references): 2,380

### **3.0 SUMMARY**

The following paper gives a reflective account of a Trainee Clinical Psychologist's experience of completing her doctoral thesis. The process of conducting the research in a medical setting as well as interviewing medical professionals will be the main focus of this paper.

### **3.1 INTRODUCTION**

*“The scientific observer is part and parcel of the setting, context and culture he or she is trying to understand and represent.”(Altheide & Johnson, 1994 p. 486).*

One aspect of qualitative methodology that is considered important in developing high quality research is reflexivity. Reflexivity is actively encouraged in many qualitative research methods and is the process of reflecting and considering one's own impact on the research process. The aim of this paper is to reflect on my journey through the research process, considering my own position and influence on the research I conducted. This is guided by a reflective journal that I kept in which I noted significant thoughts and feelings I had throughout my research. A key theme that emerged from my reflective diary was around the setting of my research and the group of participants I was researching. Therefore, the focus of this paper will be a reflection on my experience of conducting research in a medical setting with medical doctors.

## **3.2 MY RESEARCH JOURNEY**

### **3.2.1 My position at the start of my research journey**

I previously worked as an Assistant Psychologist in a medical setting and this is what attracted me to want to explore relationships between doctors and their patients. During my time in this post I had the chance to experience working from a psychological perspective in a medically trained team. I worked in this department for almost two years and I got to know most of the team very well. However, when I was due to leave the team, I noticed that I had spent very little time with the medical consultants. I remember feeling quite intimidated by them and would often opt out of opportunities to work with them. However I found them intriguing, as if in some way they were different to the rest of the team because of the job they did and the responsibilities they held.

So here I found myself, my research proposal had been handed in and all of a sudden I had a feeling of dread: now I was going to have to interview doctors. I have to admit at this time I did wonder why I had wanted to do this research; as much as I found doctors a fascinating group of people, I was not keen on the idea of interviewing them for an hour. When I mentioned to my peers about interviewing medical consultants, the reaction was always the same: a look of sympathy for my position. This led me to reflect on psychology's view of medicine and medics and how this could potentially impact on our clinical practice. In casual discussions about medics with my psychology peers, the words 'detached', 'defensive' and 'difficult' were used

frequently but rarely with a recognition of the difficult role the medic had to fulfil. Why did we have such negative views of medics? Where was our empathy for them? Apart from answering my research question, conducting this research felt like it would help answer other questions and hypotheses I had about medics that were reflective of my psychology background and my own preconceived ideas about what they would be like to work with.

### **3.2.2 My initiation**

I first met my potential participants at a department meeting my supervisor arranged for me to attend. All of the consultants present were male and between 10-30 years my senior. I suddenly became very aware of my age and gender and felt quite daunted by the thought of having to address the group about my research.

During the meeting questions were fired quickly at me in what felt a bit like an interrogation. I felt pressured to make a good impression and I was aware from previous experience of working in the medical setting that my normal nonchalant approach would just not do. In fact, on reflecting on this experience, I realised that I became much more 'medical' in this meeting. I became clear, concise and sure of myself. Similar to the medical model: no shades of grey, very black and white. For example, when asked by one of the consultants about when I would qualify my usual response would have been "I hope to qualify in September all being well" but my actual answer was "When I qualify in September I will be working as a Chartered Clinical Psychologist in a department like this".

I came out of the meeting feeling anxious and slightly cross. I felt like they had given me a harsh time. I wondered if the quick questions and tense atmosphere was a test to see if I could handle stress. I imagined medical school to be similar, with students being put on the spot and pressured into coming up with the right answer in front of all their peers. No wonder they all become so stoic, I thought. However when I came out of the meeting I had several signed consent forms in my grasp: they had given me a tough time but they wanted to be part of my research. I felt like on some level I had passed my initiation.

### **3.2.3 The main challenges I faced**

#### ***3.2.3.1 Issues of gender, culture and power***

All of the Consultants who took part in the study were male. I had not initially thought about the influence of this, however on reflection I think this impacted on the dynamic during the interviews. It is possible that my gender may have helped participants to open up more as they could have felt more comfortable expressing emotions in front of a female rather than keeping up a machismo appearance in front of a male. However, I am also aware that it may have made it more difficult to divulge personal information to me because of the difference in gender and things that they perceived to be specific to them as males may not have been shared.

My research also included participants whose ethnicity was different to my own and I wondered again if my gender added a different dynamic to these

interviews. These interviews were shorter and I felt like I struggled to glean information from these participants. In addition, some of my questions were challenged (“I don’t know, what do you want me to say to that question?”) and I found I needed to use a lot more prompts. I reflected back over my interview questions and tried to think about the language I had used and if this could have been the reason why I was having this difficulty. I then started to reflect on my position in relation to these participants, and how they saw me. It is possible that there was an influence of our differences in culture as well as gender that impacted on the interviews. I wondered if during these interviews the participants were keen not to say things that made them look vulnerable. I also wondered whether my own beliefs were impacting on the way I conducted the interviews. For example, being aware of the added difference of the participant’s culture as well as gender made me feel more anxious and may have impacted upon the way I conducted the interview.

Lastly, I noticed that I felt quite anxious and slightly intimidated during all of the interviews. I observed a power differential between myself and my participants and even though I was the person conducting the interviews I did not feel like I was in control. It is possible that this was triggered by my own preconceptions and difficult personal experiences with doctors in the past which perhaps led to my feelings of anxiety and inferiority. I also think some of these feelings can be attributed to my role as a Trainee Psychologist and the common view of psychology and medicine being in conflict or incongruent. One of the difficulties that this feeling presented was getting the

right balance between letting the participants lead the interviews while still managing to remain focused on the theme of the doctor-patient relationship. In some situations where it seemed appropriate to remind the participant of the question because they were going off on a tangent I refrained from doing so. This is something I do not think I would have found as difficult if I were interviewing service-users which highlighted to me how differences in power and authority can impact on research. It also made me contemplate my own position with clients and whether they felt such an unequal dynamic when seeing me for individual therapy.

### ***3.2.3.2 Issues of psychological mindedness***

As part of my research I wanted to access the participant's experience of the long term doctor-patient relationship. I was expecting participants to reflect on the emotional impact of caring for a patient over many years; both the difficult and rewarding experiences they had faced in the relationships and the way in which they coped with these experiences, but then I am a Trainee Psychologist and I have been taught to reflect on experience and encouraged to discuss difficult emotions. People from a medical background have not necessarily had that sort of training; in fact what emerged from the interviews was that some of the participants felt that it was necessary to actively avoid doing these things not only to cope but to 'survive' the pressures of their job.

This presented a conundrum and two issues came to mind 1) how was I going to encourage a potentially defensive group of participants to discuss

emotions and 2) defences are sometimes adaptive, who was I to try and break them down?

### **3.2.3.3 *Emotion in the interviews***

This interview set up feels very similar to when one would see a client for psychological therapy. For example: I conducted my interviews within a clinical room used for therapy, it was just me and the participant in a quiet space for approximately an hour and I was asking them to reflect on potentially emotive topics. However due to my previous thoughts about doctors struggling or avoiding expressing emotion I wasn't expecting participants to become particularly emotional during my interviews.

To my surprise, emotion did come into the interview with a few of my participants, proving that some of my assumptions about doctors were unhelpful generalisations. I found this difficult. I was in a situation that was very reminiscent of a therapeutic milieu and yet my role was that of a researcher, not a therapist. When emotion was expressed I felt helpless and in conflict between what I wanted to do and what was appropriate considering my role as a researcher.

My experience in psychology so far has led me to an interest in emotion-focused therapies, where emotion is explored and experienced in the room by both the therapist and the client. Therefore, when emotion appeared, I wanted to explore, question and stay with it for as long as possible. What was difficult was that my participants were focused on trying to defend

against emotion and often discussed emotional issues in intellectual ways.

For example, when one participant become tearful he described it to me using the Latin name for tear duct: "I can feel a tear welling up in the old lacrimal duct".

So, as quickly as emotion came it was defended against, usually in the form of intellectualisation, detachment or minimisation. Again, I had to be aware of my instinctual responses to such events as a therapist and remember that my role was a researcher. For example, in a therapeutic setting, observations of defences by the therapist can be reflected back to the client and used as an intervention to help develop self-awareness. However outside the safety of a good therapeutic relationship such observations could be potentially harmful if shared and a research interview was certainly not the place to adopt this approach. Although this was somewhat frustrating it demonstrated to me a great deal about how the participants cope with distressing situations and led me to incorporate some of these observations into my analysis of the interview data.

### **3.3 CONCLUSION**

Conducting psychological research in a medical setting has been a challenging but rewarding experience. It has highlighted to me the impact of differences between researchers and participants and the way this can influence the research process. It has also helped me to think about my own gender and culture and how this can impact on the way I am perceived by others.

In addition, the common criticism of doctors as being 'defensive' or 'detached' I found to be somewhat reflective of my experience, but I have greater empathy for why such a position is taken and why in some ways this stance is encouraged. For example, as one participant put it "I certainly stopped going to see the autopsies of patients I looked after many years ago as I didn't like seeing the patients I had looked after being cut up...it used to be considered good practice to go and watch the autopsy of a patient you were looking after to understand what was wrong with them". In a culture such as this, can we really judge doctors for trying to detach from their work?

Ultimately, conducting this research has revealed to me some of my own unhelpful beliefs about doctors, helped me to reflect on my own personal experiences with doctors and also proved to me that a lot of my original beliefs were unfounded. So I leave this research with a new found empathy for doctors and a lot more confidence in working with them and conducting research within the medical setting in future. I will never understand the stress and responsibility involved in being a medical doctor, what it feels like to save a life or lose a patient, but what I do know is that I won't feel quite so anxious about asking questions about it next time.

### **3.4 REFERENCES**

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# **APPENDIX A**

- Clinical Psychology Review  
submission guidelines
- British Journal of Psychology  
submission guidelines
- Clinical Psychology Forum  
submission guidelines

## **Clinical Psychology Review submission guidelines**

### **Ethics in publishing**

For information on Ethics in publishing and Ethical guidelines for journal publication see <http://www.elsevier.com/publishingethics> and <http://www.elsevier.com/ethicalguidelines>.

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The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: <http://www.adobe.com/products/acrobat/readstep2.html>. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

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## Clinical Psychology Forum submission guidelines

# Guidelines for Contributors

*Clinical Psychology Forum* (CPF) welcomes contributions which are **original, innovative, authoritative and of interest to the membership of the Division**. We aim to publish a variety of contributions ranging from personal reflections on clinical practice to critiques of current health policy, innovations in service development, and audit and research studies.

From time to time we commission **reviews and Special Issues**. We also act as a major communication channel between the DCP and its subsystems, and its membership by publishing a monthly DCP Chair's Column, DCP Update and various regular columns and features.

We also publish **correspondence** either regarding articles published within CPF or around issues of general interest to the membership.

Articles submitted to CPF will be sent to members of the editorial collective for refereeing. Reviewers will assess each contribution in relation to the manuscript's clarity and economy of expression; its critical and analytic stance; whether its original or innovative; and, where appropriate, that methods and results are well described, methodological sound and any conclusions drawn are valid. Overall, articles must be relevant and of interest to the profession (see *Advice from the Editorial Collective* [below](#), originally published in [CPF 227, November 2011](#), p.9). The reviewer shall then communicate directly with the authors.

Articles of **1000-2500 words** including references are welcomed. If you feel an article longer than 2500 words is justified please state the reasons in an accompanying letter and these will be considered by the reviewer.

Contributors are asked to use language which is **respectful and psychologically descriptive** rather than medical, and to **avoid using devaluing terminology** (i.e. avoid clustering terminology like 'the elderly' or medical jargon like 'patients'). In addition, language should conform to the Society's guidelines on non-sexist or discriminatory terminology. We acknowledge that language is context specific and that occasionally authors may wish to justify the use of particular terms commonly adopted within specific contexts. Please include any such qualifications within an accompanying footnote.

Please **email one electronic copy and post one hard copy** of your contribution to the CPF administrator, Sue Maskrey (details below). Please ensure that your **contact details (email and current postal address), current employer and job role** are included in case the editors need to contact you. Please do not submit articles directly to the Editor.

## Other points to consider

- All contributors should read the FAQs about publishing in *Clinical Psychology Forum* before submitting a manuscript.
- When sending copy, make sure it is **double-spaced**, in a **reasonable sized font** (no less than 11 point) and that all **pages are numbered**.
- Include a **40-word summary** (maximum) at the beginning of the paper.
- Include the **first names of all authors**, give their **job titles and affiliations**, and remember to give an **email address** and **full postal address** for correspondence.
- Please include a **word count** at the end (including references).
- Spell out all **acronyms** the first time they appear.
- Give references in the format set out in the Society's Editorial Style Guide (see below). If a reference is cited in the text, please make sure it is in the list at the end.
- Do not include **tables and figures** unless they are **essential** and save space or add to the article. All figures should be in **black and white** and easily reproducible.
- Ask readers to **request a copy** of your **questionnaire** from you rather than include the whole of it in the article.
- We reserve the right to shorten, amend and hold back copy if needed.

# **APPENDIX B**

- Quality assessment checklist
- Literature review summary table

## **Quality assessment checklist**

### **1. How was attachment measure?**

- 0- Non-standardised self-report tools
- 1- One standardised self-report tools
- 2- More than one standardised self-report tool
- 3- Adult attachment interview

### **2. How were diabetes-related variables assessed?**

- 0- Non-standardised tools, not explicit
- 1- Mixture of non-standardised self-report tools and standardised self-report tools
- 2- Only standardised self-report tools /only automated data (such as clinical measures, appointment records etc.)
- 3- Standardised self-report tools and automated data

### **3. Is selection criteria clearly described?**

- 0- Not described
- 1- Vague description
- 2- Brief/fair description
- 3- Good description

### **4. Is the sample representative of the target population?**

- 0- Sample is not representative of target population
- 1- Sample is restricted in its representativeness of target population
- 2- Sample is somewhat representative
- 3- Sample is very representative

### **5. What was the method of selection of the sample?**

- 0- Not stated

- 1- Highly selective sample (e.g. consecutive sample from a highly pre-selected group i.e. involved in another study)
- 2- Sample of convenience
- 3- Random selection

**6. Are the characteristics of the study sample clearly described?**

- 0- Not described
- 1- Vague description (e.g. information of 1 demographic variable described)
- 2- Brief/fair description (e.g. information of 2-3 demographics variables described)
- 3- Good description (e.g. information of over 3 demographics variables described)

**7. Was a power calculation used or sample size justified?**

- 0- Under powered
- 1- Not completed/not reported
- 2- Issues regarding power or sample size acknowledged/findings or post hoc calculation of power completed but a prior analysis not completed/explained
- 3- A prior sample size calculation completed and the study was sufficiently powered.

**8. Are the findings presented in light of the available literature/theory?**

- 0- No attempt to link findings to theory
- 1- Brief mention of available theory/literature
- 2- Findings discussed in light of available evidence but no firm conclusions drawn and/or recommendations made
- 3- Findings discussed in light of available evidence and firm conclusions drawn and/or recommendations made

**9. Are the limitations of the study clearly discussed?**

- 0- No discussion of limitations demonstrated

- 1- Limitations briefly mentioned although not in detail
- 2- Limitations discussed in detail
- 3- Limitations discussed in detail and recommendations made for further research

TOTAL SCORE /27

≥75% HIGH QUALITY  
50-74% MODERATE QUALITY  
<50% LOW QUALITY

**Table of studies included in literature review (in order discussed in review)**

Author	Sample	Design	Attachment measures	Other measures	Main findings
Ciechanowski et al. (2004)	N=4095 with type 1 or type 2 diabetes recruited from 9 primary care clinics in North America the Pathways Study cohort (Katon et al.,2003)	Cross-sectional	<ul style="list-style-type: none"> <li>• Relationship Questionnaire (RQ)<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Depression: The Patient Health Questionnaire (PHQ-9)<sub>2</sub></li> <li>• Patient-provider relationship: 3 items from a measure used for bipolar patients<sub>3</sub></li> <li>• Summary of Diabetes Self-Care Activities Questionnaire (SDSCA)<sub>4</sub></li> <li>• Automated data were used to obtain: treatment intensity; medical comorbidity; oral hypoglycaemic adherence; diabetes complications &amp; HbA1c</li> </ul>	<ul style="list-style-type: none"> <li>• Participants with preoccupied and dismissing attachment style had significantly greater non diabetic medical comorbidity compared with secure and fearful attachment style.</li> <li>• Participants with preoccupied attachment style were more likely to have one or more diabetes complications and were more likely to be obese compared to patients with dismissing and secure attachment styles.</li> <li>• Participants with fearful or preoccupied attachment styles were most likely to have major depression.</li> <li>• Preoccupied attachment style was associated with significantly lower risks of having HbA1c compared to secure attachment style.</li> <li>• Participants with dismissing</li> </ul>

					<p>attachment style were significantly more likely to have lower exercise levels, foot care, healthy diet and more likely to smoke and be non-adherent with medications compared to those with a secure attachment style and these associations were mediated through the patient-provider relationship.</p> <ul style="list-style-type: none"> <li>• Participants with dismissing attachment style also viewed patient-provider relationship less favourably compared to those with a secure style.</li> </ul>
Turan, Osar, Turan, Ilkova & Damci (2003)	N=89 with type 1 diabetes recruited from outpatient clinics in Turkey	Cross-sectional	<ul style="list-style-type: none"> <li>• Relationship Scales Questionnaire (RSQ) (Turkish version)<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Psychological adjustment: Lack of Integration Scale (ATT)<sub>5</sub></li> <li>• Adherence: adherence to blood tests and adherence to insulin injections measured with questionnaire using adapted subscales from SDSCA<sub>4</sub></li> <li>• Diabetes Coping Measure (DCM)<sub>5</sub></li> <li>• Nurse ratings: as a validity check, nurses working at the outpatient clinic also rated patients on coping effectiveness, general adherence and adjustment to diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Higher dismissing attachment was significantly related to poorer adherence to blood tests and insulin injections.</li> <li>• Dismissing attachment was significantly correlated with lack of integration.</li> <li>• Dismissing attachment correlated with coping responses of avoidance and passive resignation.</li> <li>• The negative effect of</li> </ul>

					<p>dismissing attachment on blood test adherence is mediated by avoidance coping and the negative effect of dismissing attachment on injection adherence is mediated by avoidance coping.</p> <ul style="list-style-type: none"> <li>• The positive effect of dismissing attachment on lack of integration is mediated by the coping style of passive resignation.</li> <li>• Fearful attachment was significantly associated with passive resignation.</li> <li>• Fearful attachment also correlated with lack of integration and injection adherence and these associations were mediated by passive resignation.</li> </ul>
Morse, Ciechanowski, Katon, & Hirsch (2006)	N= 714 patients with type 1 and type 2 diabetes recruited	Cross-sectional	<ul style="list-style-type: none"> <li>• RQ<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• PHQ-9<sub>2</sub></li> <li>• Medical Comorbidity: patients tick from a checklist of 18 listed medical conditions</li> <li>• Childhood Trauma: Childhood Trauma Questionnaire (CTQ)<sub>6</sub></li> <li>• Night eating symptoms<sub>7</sub></li> <li>• Diabetes self-care: Summary of Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Compared with participants without night-eating behaviours, those with these behaviours were less adherent with diet, exercise and glucose monitoring and more likely to be depressed,</li> </ul>

	from tertiary care in North America			<p>Self-Care Activities-revised version (SDSCA-R)<sub>8</sub></p> <ul style="list-style-type: none"> <li>• Diabetes complications: patients given a score of 0-5 to reflect number of self-reported complication experiences</li> <li>• Clinical data: duration of diabetes, BMI, smoking status, diabetes treatment also obtained</li> <li>• Automated data used to determine mean A1C values from preceding 12 months.</li> </ul>	report childhood maltreatment, to have insecure attachment styles and to report eating in response to anger, sadness, loneliness, worry and being upset.
Ciechanowski et al.(2010)	N=3535 non-depressed patients with type 1 or 2 diabetes recruited from 9 Group Health Cooperative (a prepaid health plan) clinics in North America	Longitudinal	• RQ <sub>1</sub>	<ul style="list-style-type: none"> <li>• Mortality: automated search of enrollee deaths using death registry files</li> <li>• Computerised pharmacy records were used to compute chronic disease score and medical comorbidity using the Rx Risk<sub>9</sub></li> <li>• Questions about clinical status were also included such as age and onset of diabetes, smoking, height and weight</li> <li>• Diabetes complications severity index: calculated by automated data of seven categories of diabetes complications (retinopathy, nephropathy, neuropathy, cerebrovascular, cardiovascular, peripheral vascular and metabolic)</li> <li>• Evidence of prior macrovascular and microvascular complications and coronary, cerebrovascular and peripheral</li> </ul>	<ul style="list-style-type: none"> <li>• Compared to participants with independent relationship styles, participants with interactive relationship styles were significantly more likely to be male, educated, unmarried and have higher BMI.</li> <li>• Rate of death in the interactive relationship style group was 29/1000 while in the independent group it was 39/1000 individuals.</li> </ul>

	taken from the Pathways Study cohort (Katon et al., 2003)			vascular procedures also taken from automated data using Internal Classification of Disease (ICD-9) code data <ul style="list-style-type: none"> <li>Automated data used to obtain mean HbA1c level recorded in last 18 months</li> </ul>	
Ciechanowski, Katon, Russo & Walker (2001)	N=367 with type 1 or type 2 diabetes enrolled at a 2 primary care clinic of Group Health Cooperative ( a prepaid health plan) for more than 2 years in North America	Cross-sectional	<ul style="list-style-type: none"> <li>RSQ<sub>1</sub></li> <li>RQ<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>Quality of Communication with provider: The Patient Reactions Assessment (PRA)<sub>10</sub></li> <li>Depression: 20 items from the depression and additional subscale of the SCL-90-R<sub>11</sub></li> <li>Presence of Diabetes complications: self-report checklist</li> <li>Diabetes self-care: SDSCA<sub>4</sub></li> <li>Automated data was used to obtain: Mean HbA1c for preceding 8 months, medical comorbidity and primary care utilization for previous year</li> <li>Measure of non-adherence: interruptions to treatment for patients on oral hypoglycemics</li> <li>Diabetes Knowledge Assessment Scale (DKN)<sub>12</sub></li> </ul>	<ul style="list-style-type: none"> <li>Participants with dismissing attachment style had significantly worse glucose control than participants with secure or preoccupied attachment style.</li> <li>Participants who had dismissing attachment and rated provider communication as poor had significantly poorer adherence to glucose monitoring ,significantly higher HbA1c levels and significantly more interruption in treatment with oral hypoglycemics than the other participants.</li> </ul>

Ciechanowski, Hirsch & Katon (2002)	N= 276 patients with type 1 diabetes recruited from tertiary care in North America	Cross-sectional	<ul style="list-style-type: none"> <li>• RSQ<sub>1</sub></li> <li>• RQ<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Depression: The Hopkins Symptom Checklist-90<sub>13</sub> (HSCL): 20 items from the depression and additional subscale of the SCL-90-R<sub>11</sub></li> <li>• Diabetes complications: patients given a score of 0-3 to reflect number of self-reported complications experienced</li> <li>• Medical comorbidity: estimated by having patients complete checklist of medical conditions</li> <li>• Automated data obtained to determine mean HbA1c values for each subject for preceding 12 months</li> <li>• Diabetes Knowledge: DKN<sub>12</sub></li> </ul>	<ul style="list-style-type: none"> <li>• 62 % of participants with dismissing attachment style had mean HbA1c levels of <math>\geq 8\%</math> compared with 34 % of participants with secure attachment style.</li> <li>• After adjusting for relevant demographics including depression, dismissing attachment style remained significantly associated with HbA1c levels of <math>\geq 8\%</math> compared with participants with secure attachment style.</li> </ul>
Ciechanowski, Russo, Katon, Simon, et al. (2006)	N=3923 patients with type 1 or type 2 diabetes recruited from recruited from 9 Group Health Cooperative (a prepaid	Cross-sectional	<ul style="list-style-type: none"> <li>• RQ<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Depression: PHQ-9<sub>2</sub></li> <li>• Primary care visits and missed appointments using automated data</li> <li>• Medical comorbidity using the Rx Risk over 12 months<sub>9</sub></li> <li>• Treatment intensity: automated pharmacy data regarding oral hypoglycaemic agents and insulin</li> <li>• Diabetes complications using automated diagnostic Internal Classification of Disease (ICD-9) code data for seven categories of diabetes complications (retinopathy, nephropathy, neuropathy, cerebrovascular, cardiovascular, peripheral vascular and metabolic)</li> </ul>	<ul style="list-style-type: none"> <li>• Among participants without major depression, there were more missed scheduled office visits among those with dismissing attachment style compared to secure attachment style.</li> <li>• The likelihood of having missed same day appointments was lower for those with fearful attachment style relative to those with secure attachment style in non-depressed participants compared to participants with</li> </ul>

	health plan) clinics in North America taken from the Pathways Study cohort (Katon et al.,2003)				<p>fearful and secure attachment style with major depression.</p> <ul style="list-style-type: none"> <li>• Preoccupied attachment is associated with more scheduled and same day appointments</li> <li>• Preoccupied attachment is associated with more missed same day visits compared to secure attachment style</li> </ul>
Morris et al. (2009)	N=48 out-patients with type 1 or type 2 diabetes 8 healthcare professionals recruited from two diabetes clinics in England	Cross-sectional	<ul style="list-style-type: none"> <li>• The Attachment Measure<sub>14</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Therapeutic alliance: Patient and staff versions of working alliance inventories (short-forms) (WAI-S)<sub>15</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Individuals rated as avoidant by professionals reported poorer relationships with staff.</li> <li>• Self-rated avoidance did not correlate with self and informant rated alliances.</li> <li>• Moderate levels of agreement between patient and professionals ratings of alliance were found. Less agreement between patient and professional attachment ratings were found.</li> </ul>

Bazzazian & Besharat (2011)	N= 300 patients with type 1 diabetes recruited from the Iranian Diabetes Society in Iran	Cross-sectional	<ul style="list-style-type: none"> <li>• The Adult Attachment Inventory (AAI)<sub>16</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Brief Illness Perception Questionnaire (Brief IPQ)<sub>17</sub></li> <li>• Task-oriented subscale of Coping Inventory for Stressful Situations (CISS)<sub>18</sub></li> <li>• Adjustment to diabetes: Psychological well-being subscale of Mental Health Inventory (MHI)<sub>19</sub></li> <li>• Quality of life scale of patients with diabetes (D-39)<sub>20</sub></li> <li>• HbA1C was determined by a venous blood sample</li> </ul>	<ul style="list-style-type: none"> <li>• Secure and avoidant attachment styles were found to have significant effects on illness perception however ambivalent attachment style did not have a significant effect on illness perception.</li> <li>• All three attachment styles had significant effect on task-oriented coping strategy.</li> <li>• Avoidant attachment had a negative direct effect on adjustment.</li> <li>• Positive illness perception and more use of task-oriented coping strategy predicted better adjustment to diabetes.</li> </ul>
Ciechanowski, Katon & Russo (2005)	N=367 patients with type 1 and type 2 diabetes recruited from two primary care clinics of	Longitudinal	<ul style="list-style-type: none"> <li>• RSQ<sub>1</sub></li> <li>• RQ<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Depression: HSCL<sub>13</sub>: 20 items from the depression and additional subscale of the SCL-90-R<sub>11</sub></li> <li>• Presence of Diabetes complications: self-report checklist</li> <li>• Medical comorbidity: chronic disease score based on automated pharmacy data of medications used to treat chronic medical conditions</li> </ul>	<ul style="list-style-type: none"> <li>• The degree to which participants reported being able to rely on others increased with a reduction in depressive symptoms.</li> <li>• The degree to which participants reported feeling a sense that they were not worthy of attention in relationships increased with an increase in depressive</li> </ul>

	Group Health Cooperative in North America (Secondary analysis of data from(Ciechanowski et al., 2001)				symptoms.
Ciechanowski, Russo, Katon, Von Korff, et al. (2006)	N= 324 patients with type 1 or type 2 diabetes and depression recruited from 9 primary care clinics in North	Randomized controlled trial	<ul style="list-style-type: none"> <li>• RQ<sub>1</sub></li> </ul>	<ul style="list-style-type: none"> <li>• Depression: HSCL<sub>13</sub></li> <li>• Satisfaction with care: 7 point ordinal scale for satisfaction with diabetes treatment</li> <li>• Satisfaction with provider: 6 item version of the Healthcare Climate Questionnaire (HCCQ)<sub>21</sub></li> <li>• Childhood maltreatment: CTQ<sub>6</sub></li> <li>• Social support: an item from the Interpersonal Support Evaluation List (ISEL)<sub>22</sub></li> <li>• Automated measures: computerized pharmacy refill records to determine antidepressant medication adherence. Utilization records to assess speciality mental health use</li> </ul>	<ul style="list-style-type: none"> <li>• Among independent relationship style participants, the intervention resulted in significantly greater satisfaction with depression care in the first 6 months and 47 more depression-free days (P &lt;.0003) based on the Hopkins Symptom Checklist at 12 months, compared with usual care.</li> <li>• There were no significant treatment group differences in satisfaction with care or depression outcomes among</li> </ul>

	America taken from the Pathways Study cohort (Katon et al., 2003)			<ul style="list-style-type: none"> <li>• Medical comorbidity: Rx Risk<sub>9</sub></li> <li>• HbA1c scores measured at baseline, 6 and 12 months</li> <li>• Diabetes complications using automated diagnostic Internal Classification of Disease (ICD-9) code data for seven categories of diabetes complications (retinopathy, nephropathy, neuropathy, cerebrovascular, cardiovascular, peripheral vascular and metabolic)</li> </ul>	<p>patients with interactive relationship style.</p> <ul style="list-style-type: none"> <li>• Among patients receiving the intervention, those with an independent relationship style received significantly more problem-solving treatment sessions as compared with patients with an interactive relationship style.</li> </ul>
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## **APPENDIX C**

- Additional diabetes information
- Additional information on Chronic Kidney Disease

## **Additional information on diabetes**

Taken from Diabetes UK 2012- State of the nation report (<http://www.diabetes.org.uk/Documents/Reports/State-of-the-Nation-2012.pdf>)

Without careful, continued management of the condition, a person with diabetes faces a reduced life expectancy of between 6 to 20 years. Each year, the condition is associated with 75,000 deaths; this is 24,000 more deaths than would be expected in this group. People with diabetes also run a greater risk of developing one or more severe health complications, which can greatly impact on their independence, quality of life and economic contribution. In the UK diabetes is the leading cause of blindness in working age people, and a main contributor to kidney failure, amputations and cardiovascular disease, including heart attack and stroke. One in five children who have Type 1 diabetes will be at increased risk of developing diabetic ketoacidosis (DKA) a critical, life-threatening condition that requires immediate medical attention. Many of these complications are avoidable with good risk assessment and early diagnosis, patient education, support and good on-going services. Estimates show that of more than 100 amputations carried out each week from diabetes complications up to 80 per cent are preventable.

### **NICE quality standard for diabetes in adults (taken from <http://www.nice.org.uk/nicemedia/live/13827/60174/60174.pdf>)**

The quality standard on diabetes is made up of 13 statements that describe high-quality care for patients. These statements are summarised below.

1. People with diabetes and/or their carers receive a diabetes education course to suit their needs that is delivered by trained staff. A healthcare professional should check every year whether the person would find further diabetes education useful, and diabetes education should continue to be available.
2. People with diabetes are given advice on diet and exercise from a trained healthcare professional or as part of their diabetes education course.
3. People with diabetes are involved in annual planning for their own care which includes agreeing on the best way to manage their diabetes and setting personal goals.
4. People with diabetes agree a target for HbA<sub>1c</sub> (a measure of blood sugar over the past 2–3 months), usually between 48 mmol/mol and 58 mmol/mol

(6.5% and 7.5%), with their healthcare professional, and have their treatment reviewed continuously to help avoid low blood sugar (hypoglycaemia)

5. People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure, and blood lipids (blood fats).

6. People with diabetes who need insulin receive help and support from trained healthcare professionals, including help with starting on insulin and managing their treatment. This should include advice on adjusting the dose of insulin according to their blood sugar levels.

7. Women of childbearing age who have diabetes are regularly given advice about the benefits of controlling their blood sugar before a pregnancy, and any risks such as medication that might harm an unborn baby. Women with diabetes who are planning a pregnancy are offered care leading up to the pregnancy. Women with diabetes who are not planning a pregnancy are offered advice on contraception.

8. People with diabetes are checked for additional health problems associated with diabetes (for example, eye, nerve or kidney damage, cardiovascular disease, fatty deposits in the blood vessels or sexual problems), and for the risk of developing these problems. Any risks or problems identified are properly managed.

9. People with diabetes are checked for psychological problems (such as depression, anxiety, fear of low blood sugar, eating disorders and problems coping with the diagnosis) and any problems are properly managed.

10. People with diabetes who have foot ulcers, or are at risk of developing foot ulcers, have regular check-ups from a team specialising in foot protection, and are seen and treated by a specialist healthcare team within 24 hours if they have foot problems needing urgent medical attention.

11. People with diabetes who are admitted to hospital are cared for by trained staff, including a specialist diabetes team if needed, and are given the choice of self-monitoring their blood sugar levels and, for those on insulin therapy, managing their own insulin.

12. People with diabetes admitted to hospital with diabetic ketoacidosis (a serious condition caused by a shortage of insulin) receive information and psychological support from a specialist diabetes team before and after they

leave hospital.

13. People with diabetes are seen by a specialist diabetes team for advice and support after experiencing hypoglycaemia needing medical attention (for example from a GP, paramedic, accident and emergency department, or out of hours services).

**Additional information on Chronic Kidney Disease** (taken from the National Kidney Foundation <http://www.kidney.org.uk/Medical-Info/ckd-info/index.html>)

Good management of patients with kidney disease can slow, halt or reverse chronic kidney disease. Most cases of mild kidney disease are managed in primary care, for example by GPs or practice nurses.

Advanced kidney disease is generally managed in secondary care, such as in hospitals. Hospital-based dialysis can take place in facilities that contain renal units, or in satellite centres which are run alongside these main units.

CKD is any abnormality of the kidneys that is often progressive. The damage can range from slight to much more severe. 1 in 10 people in the population are thought to have CKD, and this increases to 1 in 2 in those over 75 years of age (which can be representative of normal signs of ageing in the kidneys). The most common causes of CKD are high blood pressure and ageing of the kidneys. Very few causes are curable. Kidney function is measured by eGFR (estimated glomerular filtration rate) and is calculated by the measure of creatinine in the blood. Creatinine is a waste product of muscle metabolism that is removed by the kidneys. A normal eGFR is approx. 100ml/min in young adults. Kidney failure occurs when the estimated kidney function is less than 30 ml/min (stages 4 and 5-see below). It is estimated that 1 in 10 people with CKD will go on to develop kidney failure.

CKD has 5 stages:

Stage 1: eGFR greater than 90ml/min with slight signs of kidney damage on other tests

Stage 2: eGFR is 60-90 ml/min with some signs of kidney damage

Stage 3: eGFR is 30-59 ml/min with a moderate reduction in kidney function

Stage 4: eGFR is 15-29 ml/min with a severe reduction in kidney function

Stage 5: eGFR less than 15 ml/min established kidney failure also known as End Stage Renal Failure (ESRF) and this is when dialysis or kidney transplant may be needed.

Treatment for stages 1 and 2 involves trying to maintain a healthy blood pressure, sometimes with medication. Cholesterol is also monitored and again can be controlled with medication. Blood tests to check eGFR should be done annually.

Treatment for stage 3 is the same as treatment for the first stages but with closer monitoring.

Treatment of stages 4 and 5 again is the same as the initial stages but medications have to be reviewed to monitor their effect on the kidneys. In addition, if the kidney failure becomes life threatening, dialysis or kidney transplant may be required. Dialysis is a treatment that purifies the blood where waste products and excess water are filtered out (effectively working as an external kidney). In ESRF dialysis normally takes around 4 hours three times weekly and usually in a hospital or satellite unit. ESRF is fatal if it is not treated within a few weeks with dialysis or transplant. Transplants are not suitable for all people with CKD and there is a shortage of available kidneys in the UK. These treatments are a way of controlling ESRF but they do not cure it.

# **APPENDIX D**

- Interview schedule

## Interview schedule

**Participant Number:**

- a. Introduce self and the research
- b. Ensure participant has read information sheet
- c. Talk through the interview schedule and brief about IPA
- d. Opportunity to ask any questions
- e. Obtain written consent

### Demographic Information:

Age:

Ethnicity:

Time practising as a Consultant Nephrologist:

Would they like an executive summary about the study? (Y/N)

### **Permission to begin recording**

### Career information

1. Can you tell me about why you decided to work in medicine?
2. Why did you come to specialise in renal medicine?
3. How does it live up to your expectations?

### Experience of the patient

4. Can you tell me a bit about what you think makes a good doctor-patient relationship?
5. Can you tell me what makes a bad doctor-patient relationship?
6. Can you tell me about your own experiences of working with renal patients?

(Possible prompts: What has been most difficult/ rewarding? How did it make you feel? How do you deal/cope with it? How do these

experiences impact on the long term relationship? Are all the relationships you have with patients the same or different, how? Preferences?)

7. What qualities do you try to bring to the relationship?
8. Do you take on a particular role with patients? If so what?  
(Possible prompts: Why? Is it always the same with each patient?)
9. How do you feel the patient experiences you?  
(Possible prompt: How would they describe you?)
10. Do you think you differ to other renal consultants in your relationships with patients? How?

**Impact of own experiences on doctor-patient relationship**

11. What do you think has influenced how you act with patients?
12. How do you bring your experiences of being a patient into your relationships with patients?  
(Possible prompts: Have you ever been a patient? What sort of patient were you?)

Thank you, that's all my questions, is there anything you would like to add?

# **APPENDIX E**

- Participant information sheet
- Consent form

## Participant information sheet

Coventry University  
Priory Street, Coventry, CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8702

**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Dr Eve Knight  
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF  
**WARWICK**



### Participant Information Sheet

Participant Number:

#### **Study Title: The doctor-patient relationship when working with chronic conditions: The experience of Consultant Nephrologists.**

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research taking place and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have- this should take about ten minutes. Please feel free to talk to others about the study if you wish.

#### **What is the purpose of the study?**

This study seeks to explore long-term doctor-patient relationships in chronic illness from the perspective of the doctor. In renal medicine, this is an area which has had little research coverage, despite the increasing literature base which is supportive of the importance of the doctor patient relationship, particular in chronic conditions. This aim of this study is to explore your experiences within your relationships with your patients, and to gain a greater understanding of the doctor-patient relationship from the perspective of the doctor.

#### **Why have I been invited to participate?**

For this study we are interested in renal consultant's experiences of the doctor-patient relationship. A group of 6-8 renal consultants will take part in this study.

#### **Do I have to participate?**

No. Participation is entirely voluntary. It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. If you decide during the study that you no longer wish to take part, you are free to withdraw from the study and any data you have given will be destroyed.

#### **What will happen to me if I take part?**

If you decide to take part in the study we will then arrange a time with you to conduct an interview. This interview will last approximately 60 minutes and the focus of the interview will be on your experiences in the doctor-patient relationship. The interview will be conducted by the Chief Investigator of the study and will be audio-recorded.

#### **Dean of Faculty of Health and Life Sciences**

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

#### **Chair of Department of Psychology**

Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

[www.coventry.ac.uk](http://www.coventry.ac.uk)

04/02/2012 Version 1

**What are the potential disadvantages of taking part?**

As the study is interview based, this will make a demand on your time (approximately 60 minutes). Some of the questions that will be asked in the interview will ask about difficulties experienced in relationships with patients, which may be experienced as distressing.

**What are the potential benefits of taking part?**

Taking part in this study will offer the chance to reflect upon your experiences of the doctor-patient relationship may help to enhance reflective practise. In addition, by taking part in this study you will be helping to increase understanding of the doctor-patient relationship from the doctor's perspective.

**What if there is a problem?**

If you change your mind about taking part in the study, you are able to withdraw your data before October 1<sup>st</sup> 2012. You can do this by contacting the Chief Investigator, Hannah Pooley on the contact details below and quoting your participant number found at the top of this sheet. You are not required to state why you are withdrawing your data, and if you decide to withdraw, all your data will be destroyed and will not be used in the study.

**Will my participation be confidential?**

All the information you provide will be kept anonymous. All information you provide will be stored using a participant number and therefore will not be linked to any personal identifiable information. All electronic data will be stored as a password protected computer file. All hard copies of the data will be stored in a locked cabinet. Once the data has been analysed, it will be stored in the Clinical Psychology department at Coventry University for 5 years before being destroyed.

**What will happen to the information I give in the interview?**

The interview will be audio-recorded and then transcribed verbatim. Any personal identifiable information given during the interview will then be deleted from the transcripts. After this, the transcribed interview data will be analysed using qualitative analysis (Interpretative Phenomenological Analysis). The results will be written up as part of a doctoral thesis. This may include direct quotations that you have given during the interview process, although these will be anonymous and you will not be identified in any of the report. It is also hoped this will be submitted for publication in a peer-reviewed journal. All participants will receive an executive summary of the results of the research at the end of the study.

**Who is organising and funding the research?**

The research is organised by Hannah Pooley, a Trainee Clinical Psychologist on the Clinical Psychology Doctorate at the Universities of Coventry and Warwick. The study is being supervised by Dr Adrian Neal, Dr Julie Highfield and Dr Helen Liebling-Kalifani.

**Who has reviewed the study?**

The study has been approved by the Coventry University Peer Review process & R&D

**Contact for Further Information**

---

**Hannah Pooley**  
**Email: [pooleyh@uni.coventry.ac.uk](mailto:pooleyh@uni.coventry.ac.uk)**  
**Contact number: 07730601098**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions on the contact number provided above. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Ian Marshall at Coventry University.  
Email: [Ian.Marshall@coventry.ac.uk](mailto:Ian.Marshall@coventry.ac.uk)

# Consent form

Coventry University  
04/02/2012 Version 1  
Priory Street, Coventry CV1 5FB  
Telephone 024 7688 8328  
Fax 024 7688 8702

**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Dr Eve Knight  
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF  
**WARWICK**



## Consent Form

Participant Number:

**Study title: The doctor-patient relationship when working with chronic conditions:  
The experience of Consultant Nephrologists.**

Name of Researcher: Hannah Pooley

Please initial box:

1. I confirm that I have read and understand the information sheet dated 04/02/2012 (version one) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily by a member of the research team.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Signature

### Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

### Chair of Department of Psychology

Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

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# **APPENDIX F**

- Coventry University ethics
- NHS Research and  
Development, UHCW Trust

# Coventry University ethics

Coventry University  
Coventry University  
Priority Street  
Coventry CV1 5FB  
Tel: 024 7699 3000

**Professor Ian M Marshall**  
Pro-Vice-Chancellor (Research)



TO WHOM IT MAY CONCERN

RRU/Ethics/Sponsorlet

08<sup>th</sup> May 2012

Dear Sir/Madam

**Researcher's name: Hannah Pooley**

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed (ref: P4516).

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

**Professor Ian Marshall**  
**Deputy Vice-Chancellor, Academic**

Enc

**Pro-Vice-Chancellor's Office**  
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17<sup>th</sup> July 2012 - Revised 18<sup>th</sup> July 2012

Miss Hannah Pooley  
Psychology Department  
St Michaels Hospital  
Warwick  
CV34 5QW

Dear Miss Pooley,

**Study Title: The Doctor-Patient relationship when working with chronic conditions: the experience of Consultant Nephrologists.**

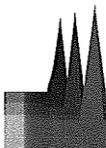
Thank you for submitting the above study for consideration by the Research & Development Office. I am pleased to inform you that your study has been approved.

The documents approved for use in this study are:

Document	Version	Date
Participant Information Sheet	1	4/02/2012
Consent Form	1	4/02/2012
Protocol	1	18/02/2012

- Should you wish to make any changes to the documents listed above, you must obtain R&D approval prior to use.
- A Development Safety Update Report (DSUR) should be submitted to R&D. The first report is due on **17<sup>th</sup> July 2013**. The DSUR replaced the Annual Safety Report (ASR) on 01 September 2011. Guidance on the DSUR can be found in SOP 5 'Regulatory Approvals and Communication' on the Trust R&D Intranet.
- Notification of any serious breaches of GCP or the trial protocol must be reported to the R&D Department and a DATIX Clinical Adverse Event form completed within 24 hours of any suspected breach being identified and confirmed.

R&D Reference: HP106312



Your research sponsorship & Indemnity is provided by Coventry University.

Your project may be subject to ad hoc audit by our department to ensure these standards are being met.

May I take this opportunity to remind you that, as a researcher, you must ensure that your research is conducted in a way that protects the dignity, rights, safety and well-being of participants. Trust R&D Approval assumes that you have read and understand the Research Governance Framework and accept that your responsibilities as a researcher are to comply with it, the Data Protection and Health & Safety Acts.

The Trust wishes you every success with your project.

Yours sincerely



**Natasha Wileman**  
**R&D Business Manager**

Cc:  
**Ceri Jones, Head of Research & Development**

Professor Ian Marshall – Sponsor Representative – Coventry University

R&D Reference: HP106312

## **APPENDIX G**

- IPA analysis guidance
- Annotated transcript
- Table of themes with supporting quotes

### **Process of IPA analysis as based on guidance by Smith, Flowers and Larkin (2009)**

- (1) Each transcript was read and re-read to become familiar with the data.
- (2) Each transcript was coded individually with the analyst making initial notes which in the following forms: descriptive comments, linguistic comments conceptual comments (the beginnings of interpretation). Descriptive comments were made in the left hand margin. Conceptual codes were noted in the right hand margin.
- (3) The analyst went through each transcript again, making notes of emerging themes in the right-hand margin and condensing initial notes into concise phrases representing the content of the interview (for the purpose of this study, emerging themes were noted on a separate piece of paper due to space restrictions).
- (4) The process was repeated for all other transcripts (during this process the analyst is encouraged to 'bracket' off knowledge acquired from the other participants analysis so as to start each transcript analysis from an objective view point to avoid influencing the themes identified).
- (5) All of the transcripts were brought together to identify shared themes for the group as a whole (emergent themes).
- (6) These emergent themes were then grouped into subordinate themes that represented the data.
- (7) The analyst then looked for connections between subordinate themes and clustered them together to form superordinate themes.
- (8) The analyst then checked back to the transcripts to ensure that each theme was represented by the data.

**Sample annotated transcript from two participants (emergent themes are underlined)**

704 worse it must be for them than for me erm and so it quickly  
 705 puts it back into into perspective. (9) Perspective as coping?

706 **I: Hmm so do you think thinking about it that way is helpful**  
 707 **for you?**

708 Patients P: Yeah I think it is. I think all the time I try to look at things (22) Empathy  
 709 perspective from the patient's perspective. I constantly try to remind Patients not  
 710 myself that these are patients and not diseases. I think you diseases  
 711 Patients not need to erm everyone you see you should be thinking would (74) People not  
 712 diseases I, if this was my grandfather or if this was me, you need to ask diseases  
 713 yourself that question every day. And so, so yeah I think if (22) keeping  
 714 Frustrations something is affecting you weather that is a difficult Re empathy  
 715 occur - you conversation with a patient or erm frustrations because  
 716 need to see things are busy and you can't get something done because of Empathetic  
 717 it from the hospital bureaucracy I think you do need to think I think Stance  
 718 patients side you need to turn around and look at things from the patients  
 719 perspective you know and try to see how they would prefer,  
 720 Understand what treatment they would prefer and understand what their (75) Connecting  
 721 their emotions sort of emotions are as well rather than yours. with patients  
 722 **I: And on the other side of it what would you say has been emotions  
 723 your most rewarding experience working with renal acknowledging  
 724 patients? the psychological  
 aspect of being a  
 patient**

725 Most difficult P: Erm (long pause) almost the same thing. And I think (70) — Something  
 726 Can be most sometimes the most challenging can be the most rewarding good from  
 727 rewarding at the same time erm and getting acknowledgement from something bad  
 728 those same family members after one of the patients has Positive reframing  
 729 Acknowledgment died after those decisions were made a week or two later (13) High risks =  
 730 from family erm sort of cemented the fact that I think it was something high rewards  
 731 that was done well and correctly erm and yeah I think Rewards of  
 732 Justified it justified the difficult conversation. One example is the patient acute  
 733 had been on dialysis for a long period of time and had a bad Reassurance (76)  
 734 V. sick patient heart, dreadful blood vessels and diabetes and got dreadful  
 735 foot ulcers and was recurrently getting infections from these  
 736 Not fit enough foot ulcers and they were just incurable and he wasn't fit  
 737 for op enough to have an operation so he basically had to die a fairly  
 738 unpleasant and unpredictable death from his foot ulcers at  
 739 Pull out at some point in the coming weeks. His option was to pull out of  
 740 dialysis which would mean he would die of kidney failure erm  
 741 & die from but people who die of kidney failure tend to do so in a more  
 742 kidney failure peaceful way than someone dying of a septic foot which  
 (44) Role of  
 carer? Healer?  
 Role/identity  
 as a  
 nephrologist  
 His role is  
 not about  
 curing.

743 could pass away peacefully  
744  
745  
746  
747  
748  
749 Patients make brave decisions  
750  
751  
752  
753 would be easy to just carry on but you would regret it  
754  
755  
756  
757  
758  
759 Relatives come & thank you  
760  
761

would be painful and infection is awfully uncomfortable where as if you stop dialysis the kidney toxins will end up going into a bit of a coma and peacefully passing away so the decision to do that in a time frame of his planning in a place of his choosing in a manner that really was going to be peaceful compared to taking the chances of what's next going to happen. So its really brave decisions for patients to make those decisions and...not not brave but brave to have the conversation for us to suggest it because the easy thing is not to put patients through the difficulty of having those difficult conversations it would be very easy to say oh lets just go and see how things go erm but you do regret do doing that cos it often ends up with you looking back and thinking I wish we'd had the brave decisions to pull out of it at an earlier point in time. So yeah I think having made those decisions in conjunction with the patient and their family erm and then seeing things end peacefully and having relatives come back and say yes thank you for those conversations and what you have done is quite a a rewarding part of the job.

Finding positives in difficult situations  
Role as more than medic  
39) Doesn't take uncertainty  
Rumination  
66) Ruminate over bad decisions  
79) Regrets easier to cope with if seen as positive reward  
rephrasing here

69 Can't teach intentions necessary aspect of modern medicine I think but but there is  
 70 an element that we are not taught in medical school that  
 71 Wanting to make people better - you genuinely try and make another human being better. I think I think that's the thing  
 72 about medicine and I know I know erm I think it's a noble  
 73 profession actually maybe I'm old fashioned but I think I think  
 74 Noble profession there's a degree of niceness about it. — Medicine is kind, giving profession

(17) Role as a doctor - have to have good intentions  
Professional Identity

76 I: And that humanity aspect- what do you mean by that? sense of privilege

77 Unique position: Well well you you you are in a unique position to alleviate  
 78 human suffering I mean just like nurses can provide care and  
 79 Nurses have - and if a patient is in need help they can provide that if a  
 80 similar position patient has soiled themselves because they have not got their  
 81 Nurses help patients gain self-respect own dignity and whatever and because they are unwell and  
 82 vulnerable they are not in a position to erm for instance they  
 83 have soiled themselves the nurses would clean them up and give them the sense of self respect again. In a similar fashion I  
 84 Drs can alleviate suffering think although slightly different but but in a similar way as a  
 85 medical doctor you are in a position to alleviate human  
 86 suffering and to help somebody who is unwell I mean  
 87 People don't want to be in hospital nobody, obviously there are a few exceptions, nobody wants  
 88 to come into hospital they want to be out there living their  
 89 lives and when they come into hospital seeking your help I  
 90 mean all you have to do is put yourself in their position, how  
 91 would you like to be treated? And you treat them in the same  
 92 way and you try and help them genuinely not because this is  
 93 Treat them how you want to be treated a job where you earn money or not because er your director  
 94 or the medical director is looking to see how many patients  
 95 you have seen and what you have done. It isn't the numbers  
 96 Not due to money of the statistics or the tick boxes it's that you know you  
 97 Form connection connect with the patient on a different level.

(19) Power of healing - this role is to stop suffering  
Reflecting on his role  
 (17) Role as a doctor - give a powerful position of  
 (23) Feeling privileged to do  
 Doctors are unique  
 (21) This is much more than a job to him  
 Trying to empathise with patient  
Empathy for patients  
 Medicine is not just a job  
 (22) Connections are important  
Connecting through healing

99 I: And what's that like for you being in that position?

100 Honoured to do it P: I like that and I think I think er I think I'm privileged er it  
 101 is actually an honour to be able to do that. When I see a  
 102 Patients tell him personal things patient in my clinic and they they tell me very personal things  
 103 about themselves expecting it to be expecting to be treated  
 104 with respect to be to be you know whatever they say to you  
 105 is entirely confidential er you you must take hold of that and  
 106 Respect confidentiality sometimes I am humbled by being in a position where people

(23) Pride  
 (24) Sharing experience  
 Connecting with them

107 tell me things like that you know I feel good about it because  
108 I can help I think and I like doing that — wants to help people

109 **I: And you said about you having to earn their trust, what do**  
110 **you mean by that?**

111 *Patients trust you* P: Well I er I mean to some extent I expect the first time <sup>(25) Trust as the</sup>  
112 *brought up to trust* when a patient walks in they have never seen you er they <sup>foundation to good</sup>  
113 *dr's* they er they expect they they probably come in already <sup>relationship</sup>  
114 *As a child you trust* biased towards trusting you because we are brought up — He respected dr's  
115 *dr's* trusting doctors you know when you are a child if you have a <sup>as a child - did</sup>  
116 *Easier because* problem you go and see the doctor so that that label of <sup>this influence his</sup>  
117 *of this* somebody you look up to and trust and you go and speak to <sup>career choice</sup>  
118 *Put patients at* them so its made easy with that but but if you put a patient <sup>Trust in the</sup>  
119 *ease & treat* — at ease and you speak to them with respect and you explain <sup>relationship</sup>  
120 *them respectfully* things to them, I think communication is key really when you <sup>(26) Importance of</sup>  
121 *Communication is* speak to them and you don't treat them as as er <sup>communication</sup>  
122 *key* condescending really you are not patronising to them er you <sup>— Dr status</sup>  
123 *Earn trust quickly* very quickly earn their trust because they are already halfway <sup>implies trust</sup>  
124 *as they are* there more than halfway there. <sup>already</sup>

125 **I: Yeah and do you think what you are talking about is for**  
126 **general medicine?**

127 *Not all patients* P: It can go across the board I mean I guess I guess if I if I <sup>In short term</sup>  
128 *need to reveal* came to if I if I was a patient and I have an ingrowing toenail I <sup>trust is problem</sup>  
129 *personal things* mean I don't have to reveal personal things to them I trust <sup>focused</sup>  
130 *Trust is around* — them that I have a problem that they can sort out and <sup>(28) The patient</sup>  
131 *the problem* hopefully they can sort it out and so so my degree of trust is <sup>as a whole,</sup>  
132 *Get to know* compartmentalised there to that that thing. I think when you <sup>not the problem</sup>  
133 *patients more* — when you get to know a patient a bit more and you see them <sup>(27) Relationships</sup>  
134 *Dialysis patients* in for instance dialysis patients that you see in various er you <sup>based on knowin</sup>  
135 *have different* know at various times with various ailments not necessarily <sup>them as people</sup>  
136 *illnesses* related to their renal impairments er over a period of time <sup>(27) Almost like GP</sup>  
137 *Over time they* they develop trust in you and they tell you things that <sup>role? Role</sup>  
138 *develop trust* probably don't have anything to do with their current <sup>(29) Renal relationship</sup>  
139 *Tell you personal* problem it's just like when they speak to nurses they get to <sup>are different</sup>  
140 *things* see lots. <sup>His role is more than</sup> <sup>★ Positives of</sup>  
<sup>a medical doctor?</sup> <sup>long-term</sup>  
<sup>relationship</sup>

141 **I: So what makes a good doctor-patient relationship in renal**  
142 **medicine?**

**Table of themes with supporting quotes**

<b>Superordinate Theme</b>	<b>Subtheme</b>	<b>Supporting Quotes</b>
<p><b>Theme 1: Defining my professional identity</b></p>	<p><b>T1a: More than a medic</b></p>	<p>Alan: ... I think being a doctor to a certain extent is very much like being a public relation and how you manage your patient in a way that is not to offend them and still do a good job I think it's a trick of the trade that you learn over the years. (156-160)</p> <p>Alan: Erm I might deal differently with people but that's the nature of our, our job, that it's a lot of it is public relations so you talk to your patients a lot of the time. (374-377)</p> <p>Alan: Sometimes they say well look I am feeling really tired and they may well know there's no pill for tiredness but I think they want you as a doctor to perhaps sympathise and say "Ok I see your tired or I'm sorry to hear that" so they probably want that kind of assurance from you that yes you are tired but don't worry it's of no consequence. (448-454)</p> <p>Brian: It's become much more to do with communicating and and helping people and having people feel better about their disease and and about themselves and where they are. I think we do just as much good by reassuring people that life goes on and there will be problems and we can generally find a technical solution but to actually have them feeling good about that and using my knowledge and understanding to give them a little bit of of confidence about what's going on. And they can't alter the fact that they have got a bad disease or that it's a chronic disease or that things go wrong, but they can have confidence in the fact that whoever is helping them look after it is doing so with a good sort of knowledge base but also with a regard for what they want and who they are and their feelings and so on. (50-55)</p>

		<p>Christopher: ...you know whether that's a week in hospital or a lifetime on dialysis all of it's a journey and I think you have more responsibility than just making the right clinical decision on one particular day. (879-883)</p> <p>Michael: Erm well it's, I think over the years it's not as much about diagnosis and treatment as about the way you behave with people. (431-432)</p> <p>Richard: I think it's an art with a bit of science chucked in and erm and my interests now are much more to do with healing. Not healing in terms of making people better because nephrology you have probably learnt by now is not a specialty where we cure many people, but healing in terms of giving patients a prognosis and some hope. (18-23)</p> <p>Richard: I suppose as renal medicine is pretty much a chronic disease you get to know people over a number of years and in that way it's a bit like general practise there's the added element of erm paternalism I suppose that you are their long term carer. (266-270)</p> <p>Christopher: I always introduce myself by first name, I present myself as their sort of advocate rather than their decision maker and try to put things across that we are a team, that we are going to make these decisions together and so try to put things on an equal footing. (776-781)</p> <p>George: And you treat them in the same way and you try and help them genuinely not because this is a job where you earn money or not because er your director or or the medical director is looking to see how many patients you have seen and what you have done. It isn't the numbers of the statistics or the tick boxes it it's that you know you connect with the patient on a different level. (92-98)</p>
	<p><b>T1b: Comparisons</b></p>	<p>Alan: In cardiology maybe it's different because you see them once, you correct the condition and you know medically you don't have to see them these days similarly in</p>

	<p><b>to other specialties</b></p>	<p>other specialities such as surgery you don't have to see them beyond their operation, once they are well they are discharged. In nephrology, you really see them, er, for most of their life. (55-61)</p> <p>Alan: In any case I mean that's my own feelings is that most of the physicians to a certain extent are introvert as opposed to surgeons who are more extrovert people and we do tend to be err to be easy to to approach. (193-196)</p> <p>Brian: I think there is a big difference between renal which does, although it's pretty technical in many ways, it does incorporate this long term approach with chronic conditions. I think if you're just you know somebody comes in with chest pain is it or is it coming from the heart, you get your test and you know that's a very different technical medical association. (391-397)</p> <p>Christopher: I didn't so much like the fact that all the patients were sort of ventilated and you sort of lost that interaction but I really enjoyed the physiology, the sort of medicine aspect and then went to renal and found that it was sort of like a sort of slight step down from ITU in that the patients were all very sick and you could apply the same set of principals but you were dealing with patients who were awake and who you could speak with and interact with. (65-73)</p> <p>Christopher: So where as if you're dealing with a patient in general practice you may be seeing them infrequently over a long period of time but they might have some er minor issues that you may or may not make better, and I'm sure, my perception of that not being in general practice would be that I might find it hard to see the impact and the success of that over a long period of time. (109-115)</p> <p>Michael: I seldom see a new patient if you like, well I do the ward work, but the majority of the work is reviewing people I have been treating for many years anyway and some of them I see more often than the GP does. (198-201)</p>
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		<p>Philip: ...and the A&amp;E consultant was saying they just see people for 4 hours they don't even have time to build a relationship with them but I thought, if someone comes to me with a chronic kidney condition I'm going to be looking after them probably for the rest of their my career or something like that. (86-94)</p> <p>Philip: Er but no there is chance to build that up and that is something I find interesting about it and that is something that in you have in common with GPs you know you are going to be looking after someone for the rest of your career unless they move out of your patch so you get the relationship etcetera etcetera so there is that aspect. (107-113)</p> <p>Richard: Erm not much it's pretty much the same. I suppose as renal medicine is pretty much a chronic disease you get to know people over a number of years and in that way it's a bit like general practice there's the added element of erm paternalism I suppose that you are their long term carer. (266-270)</p> <p>Richard: You also often have because it's a long term relationship you have the extra burden of previous mistakes, it's a bit like a GP, that if you know if somebody in your team messed something up 10 years ago you may have forgotten about it but they haven't and you are carrying round that extra sort of er it's a bit like erm being unfaithful to your boyfriend or girlfriend even though she doesn't know and it happened 10 years ago it's still a burden you carry because it might come out one day and you don't want it to come out. (295-304)</p>
	<p><b>T1c: Liking the long term relationship</b></p>	<p>Brian: And I just liked the long term association with patients. I would not like with er, in a specialty where you see a patient, do something technical and then send them away again. (108-111)</p> <p>Christopher: So they are not just acute and sick and complicated they are also patients who once they head to the renal services they tend to be there forever</p>

		<p>because once you get an established renal failure or and advanced chronic kidney disease you either end up in the clinics forever or on dialysis. And even if they get a kidney transplant they stay in services. So you stay with the with the patients forever. And I really like that aspect of it, the chronicity of the patient under your care who then stays under your care forever. (82-88)</p> <p>Michael: So it can help with that sort of urm judgement er, as I say some of the people ones more friendly with, which I like, you know going through and getting married and having families, a series of jobs. So you you get to hear a bit more about that. (347-351)</p> <p>Philip: So huge numbers of patients over a long length of time so it gives you chance to build up a a rapport and things like that with people so I think that's the other aspect. (91-94)</p> <p>Philip: Yeah, well because you, it it is building up a relationships that is a real positive side of things. (103-104)</p> <p>Philip: You do get actually a perhaps a little bit more of a positive because you know the person as opposed to A&amp;E you know they come in and oh thank you very much doc for stitching me up and walk off again. It's not the same thing as as somebody who you have looked after for 5 or 6 years. (490-494).</p> <p>Alan: I mean from, from a doctor-patient, I mean from a doctor point of view, its slightly easier because next time when you see them of the next time you see them after few visits it becomes much easier to actually deal with them and if they run into problems actually it doesn't take us that long to figure out what's, what's wrong with them so you quite quickly grasp diagnosis. (78-84)</p>
	<p><b>T1d: I need more than just</b></p>	<p>Christopher: So that was the immediate reason for me wanting to look into renal in more depth there was this sort of spectrum. You've got the chronic end of the</p>

	<b>the chronic work</b>	<p>spectrum where you are looking after this community of patients forever and having the trust aspect but you I think I would miss the complicated acute illnesses that you can't get in general practice and then at the other end of the spectrum I'd miss the patient interaction and chronicity, once you make them better you discharge them to the ward and never see them again really. (94-103)</p> <p>Michael: Yeah it feels good. It sounds terribly arrogant but the lady from X who was transferred to us because X couldn't offer a transplant at the time who falls in the category of risk who most people in the world say you shouldn't transplant on and she reckoned she was gonna be dead on dialysis in a couple of months' time, erm yeah we made her better. (330-335)</p> <p>Richard: (Discussing the most rewarding aspect of his work) I suppose it's the double handshake which you sometimes get from patients when you know you've saved their life, they know you have saved their life, you know they know that you have saved their life and they want to say thank you and they shake your hand and they usual put the other hand and grip you hand and they say "<i>Dr X you saved my life</i>" and you say "<i>No no it was the team and it was X and X and the team did it</i>" and they say "<i>No its not X and X and the team it's you</i>" and I find that very very very emotional (starts to cry) er because sometimes you think hey it was me actually you know and that's why they are walking round this earth. (576-587)</p> <p>George: Er the most rewarding aspect is when you see a patient who is almost dying and you treat them and the next day they are sitting up looking at you and smiling and saying thank you. There's nothing that beats that. (240-243)</p> <p>George:...er I asked I asked for a bit of medical history and realised that the patient was a diabetic and a vent on and give her some 50% dextrose and half an hour later she was sitting up and she was talking with her family and er I was a very very junior doctor then and that made me feel so good (laughs slightly) because she was dying</p>
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		<p>and she woke up and she was speaking with her family. (259-265)</p> <p>George: I mean you you recognise that this patient is unwell you treat the patient the patient gets better and that satisfaction you get inside you it's indescribable. (275-277)</p> <p>Christopher: Whereas if you've got somebody who's come in and is acutely unwell and you can make them better in the next two days, you see that result right in front of you and its quite rewarding and satisfying thing to go home at the end of the day and think actually I made a bit of a difference coming into hospital today. Erm, I think that's er I think I er (pause) find that I quite need in my work. (115-122)</p> <p>Richard: Yeah I suppose it's when people are acutely unwell and they have say a myocardial infarction or a pneumonia meningitis they quite often get ill quickly but they get better quickly so as a doctor you get short term gratification from that whereas, so I've always found that exciting you know that when the pressure is on and when they are in the resuscitation area of the A&amp;E department because they have got water in their lungs because of kidney failure, you know that you and your team can make a quick diagnosis So just as they have got ill quickly you can get them better quickly and that's exciting to me. (88-98)</p> <p>Richard I have volunteered to do more of it a lot of the other consultants here only do nephrology but I do acute medicine and work in the emergency department two days a week which I don't have to do but it's because I like this thing of becoming sick quickly and getting people better quickly. (101-105)</p> <p>George: The acute part of it is when the patient comes in and they are very ill and you treat them and they get better and sometimes you see them and sometimes you don't but it's also very satisfying. (42-46)</p> <p>Richard: I suppose as I have got older I think I have started to enjoy the chronic work</p>
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		<p>more, the cold work the clinic work, so I now enjoy both maybe when I started I found the clinic work you know a little dull but it's equally important because if you do good clinic work you can keep people out of hospitals and you know given the choice they would prefer not to have an acute illness so I suppose over the years as the aging process has gone on and I've slowly lost my hair then I've enjoyed that mixture of work. (117-125)</p> <p>Alan: And I think nephrology is fascinating in the sense that there are so many facets of medicine and basic sciences involved in it, so right from oncology to basic sciences an application of medicine, different branches of medicine such as hypertension, diabetes, immunology. So it gives you a very, it makes you a kind of all-round doctor so I think that's what attracted me. (10-16)</p> <p>Philip: I was saying about our specialty compared to his is that we get the whole spectrum of everything you have the er emergency side of thing, the transplantation and all that and also you have the outpatients. (81-86)</p> <p>Philip: : Yeah there's a big variety of different things and I like it because you're not you know we do different things you are on call and that's very busy and then we do clinics and things like that so there is a variety of things and that keeps you keeps it very interesting. (96-100)</p> <p>Richard: Yes well nephrology provides a nice mix of the acute work when you are in the emergency department and the long term work the clinic work. So you are flipping between the hot work where you have to make quick decisions and the cold work and that's quite a mental challenge to keep speeding up and slowing down and I think that's another attraction of a of a speciality like nephrology again it's not everybody's cup of tea, some people prefer to work at one pace rather than like this but I I quite like it, it appeals to me. (107-115)</p> <p>George: It's amazing what nephrology can do erm it's got got an excellent mix of</p>
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		<p>chronic and acute and er potentially treatable problems and there is transplantation as well there's procedures as well so I think it's the complete speciality. (25-29)</p>
<p><b>Theme 2: Relating to the patient</b></p>	<p><b>T2a: The patient is a person</b></p>	<p>Brian: Umm so it's not so much caring for them as understanding the variety of humanity and the human responses and what humans do and how they treat each other and how they relate to each other. (23-27)</p> <p>Alan: I think (pause) you know just trying to get to know them a bit more beyond being a patient-doctor relationship and I think that's one of the things in nephrology in that you see those patients for over 5 years, 10 years and 20 years and you get to know not only them but their family as well so I think that's probably... the basic things is really communicating with your patient well and that's probably the key thing (quieter). (32-39)</p> <p>Christopher: And so I think so I think that compromise is necessary you need to erm to give the patient an impression that you are seeing them as a whole you are not seeing them as one organ in the body. (401-404)</p> <p>Christopher: If you were just going to guidelines without acknowledgment of the patient in the middle of this, if it was just the disease, it would be very easy to say 'this is the right answer'. (605-608)</p> <p>Philip: ...so it is important that you take the patient holistically and not just look at oh here's your kidney test but actually there are other things there. (269-272)</p> <p>Philip: So everyone is an individual and it's important that they feel treated as an individual and listening to them rather than saying this is the treatment, have this no matter what else happens. Well can we tailor it for me? That's the important thing. (568-573)</p>

		<p>George: I think I mean I would have some inkling of how the patient thinks and how the patient I try to get into people's heads but I do that out of work as well that's how I am. So I try to get into people's heads and see see how they are as human beings but it might be difficult in the first instance but over a period of time you you get to know them. (350-356)</p> <p>George: Well if if you see patients who have got long standing diseases that they have had for years and year and you get to know them quite well and you get close to as you get to know them as people rather than just you know patient 33 that goes away. (33-37)</p> <p>George: You ask them about things they have done and you get to know a bit about their social lives so I often ask patients what they do or have they had a good weekend and things like that. It doesn't necessarily have anything to do with their medical problems. (370-374)</p> <p>Brian: I like her cos she's a teacher and she was a nurse and she's very open and there's no question we could easily be friends and we weren't in a professional relationship and that's really nice you know (799-802)</p> <p>Philip: I usually try and find out something about the person you know they might like their garden, they might like this, so with some of the patients you can talk to about that so you just get so they can sort of get a feel, they feel there is something there that they are not coming to meet a faceless person who just sits there in inverted commas in a white coat and says do this do that do the other. So you have got a bit of something there that you can talk about as opposed to just the condition. (193-201)</p>
	<p><b>T2b: Finding empathy</b></p>	<p>Christopher: And when you reflect on it as much as you feel sort of emotionally drained at the time you need to then think of it from their perspective and how much worse it must be for them than for me erm and so it quickly puts it back into into</p>

		<p>perspective. (701-705)</p> <p>Christopher: I think all the time I try to look at things from the patient's perspective. I constantly try to remind myself that these are patients and not diseases. I think you need to erm everyone you see you should be thinking would I, if this was my grandfather or if this was me, you need to ask yourself that question every day. (709-713)</p> <p>Philip: We are not in isolation and therefore you know people who are having struggles to cope with their medication or whatever, there are often reasons why. People don't want to make themselves ill so we need to understand the background as to why that person is not doing what we say to do or whatever, it's not a case of not wanting to do it it's a case of other things impounding on their life's and things like that. And also you know we come back from holiday and we have good resolutions or New Year's resolutions and things like that- they all disappear soon (laughs). So those are the sort of things, and if you have that idea of how difficult it is to with an illness such as kidney failure, to keep those good resolutions and things like that all the time then yeah it is the reality. (257-263)</p> <p>Richard: Er relatively few doctors are lazy or don't care but often they can lack the ability to listen to the patient understand the patient try to understand the patient and its sometimes difficult you know most of us come from very posh upper middle class background so we don't naturally understand or empathise with you know the proletariat and er but we can learn and and and you can better at it as well. (376-383)</p> <p>Richard: I suppose I particularly like difficult young men because the difficult non-compliant young man is very frustrating many of them will come your way, maybe because I was a difficult young man once so I understand where they are coming from. (332-336)</p>
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George: Well I try not to, I'm not judgemental as far as patients are concerned so I don't make judgements about what they do. I I try to I try to empathise so if I know there are certain patients who smoke despite the fact that they shouldn't be smoking erm I know there are patients who erm don't take their tablets despite the fact that they you tell them to take their tablets and it's very frustrating because they they actually lie to you and they tell you erm you know they're not doing it and I try to empathise with them and I try to genuinely to say what would it be like if I was in their position erm that can be a bit erm you know you have to work at it because it takes it takes patience to learn to accept that patients will do what they do to I mean we label them as patients as if they are a different sort of species but they are just like you and me and we might have our own ailments and we go and see other doctors for and wouldn't be taking our tablets properly so erm yeah I don't know what I was talking about. (289-306)

Brian: The trouble is, I could not have had a more privileged upbringing, you know I went to a fantastic prep school, public school. You know, I've lived in some of the oldest and loveliest buildings in the country and still do. Erm it's not palatial, it's not aristocratic in any sense, it's just upper middle class. Erm, and er heaven knows, heaven knows, I mean I know how my peers tick, I don't necessarily like how they tick but I know how they tick erm, I'm a million miles from knowing what makes half my patients tick, deep down. I should think half of them are scared stiff of me, you know. (1163-1173)

George: You know you have to work at it because it takes it takes patience to learn to accept that patients will do what they do to I mean we label them as patients as if they are a different sort of species but they are just like you and me and we might have our own ailments and we go and see other doctors for and wouldn't be taking our tablets properly so erm yeah I don't know what I was talking about. (299-306)

	<p><b>T2c: Being a patient has helped</b></p>	<p>Alan: I mean the last four months and er, I've just been unwell and just come back working for last couple of months and I think on occasions I do, maybe it's a bit early since I've had this problem but I do kind of now see how a patient, so I sometimes now see in the position of a patient, and look look inwards, outwards, however you want to look at it, how would I be when I'm a patient and how are doctors treating me now so it has changed but when I I compare how I was before and now I think I was still doing all those things unconsciously or consciously perhaps now more consciously than before so I am now conscious that I have been through this and my expectation as a patient are these. (407-418)</p> <p>Alan: At the moment I I'm conscious of the fact of what has happened to me and when a patient is is is telling me all the problems I as a patient do think as a patient. Being a doctor I still think of what the patient expects of me. Whether it's just a bit more sympathy erm, so I think I was still doing it before but without being conscious of it. Now I am a bit more conscious of it that yes they expect a certain kind of er er response from me which, but again I I really haven't changed that much. I'm probably more conscious of it but that hasn't changed my practise. (426-435)</p> <p>Brian: I was a bit depressed at one stage you know erm yeah I'm a much much better doctor through having experience one's own frailties definitely. (1248-1251)</p> <p>Brian: But having said that I really recognise the value of having faith in your doctor. I really really value that. And er I mean I have been a patient and I've got a really good GP and I trust his judgment completely erm and so I would I would take advice. (1216-1220)</p> <p>Brian: So I think my personal experience, my my personal physical frailties help me a lot because they are with me all the time but how my GP reacted to that is not hugely different to what I got from other doctors that I'd been associating with either</p>
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		<p>colleagues or in training contexts. (1280-1284)</p> <p>Michael: But I think something like that happening makes you realise how it's very easy to have unrealistic expectations you know what healthcare is going to be like when you are a consumer of it. (455-458)</p> <p>Michael: You know its erm, you you could see particularly from my father and mother in law that your expectations and experiences as the consumer of the healthcare are very very difficult. Erm and er perhaps when I am on the wards I try and make things a bit simpler and clearer and even if it's not going to be for a few weeks or two I try and keep telling people what their discharge date is going to be because that is what most people are interested in when they go to hospital, it's not what's going to happen tomorrow it's when they are getting out of the bloody place (laughs). (464-473)</p> <p>Philip: I didn't say to him you have just been the most unprofessional you know I hope he never ever treats another patient like that. But having a negative experience like that is the thing you know, someone who's too, and someone said to me the other day I went to see my doctor, and he spent the whole time on the computer didn't actually look at me didn't do anything and said your blood pressure's high and you know something in his life that had cause him to be really upset that day and you know he said doctor you spent 5 minutes chatting and you took my blood pressure and it was ok. So it is that sort of thing so you you I think you learn from negative experiences and actually like everybody says you learn more from your mistakes or more from your failures than you do from your successes and that that's very true. (736-750)</p> <p>Richard: I mean I was pretty sick with the rugby related bleed in my thigh I could have lost my leg but having been through it I was a hell of a lot better doctor. (919-921)</p> <p>Richard: First of all there was, one of the doctors with my leg made an error,</p>
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		<p>fortunately it wasn't too bad we delayed the operation by 24 hours I mean I needed urgent surgery and this guy missed it so it made me realise doctors make mistakes if you make a mistake somebody can lose a leg or die I mean I knew that from my own as a kidney doctor but it was quite helpful to be on the other end of it and you know what a bummer if you died unnecessarily because of a doctor's mistake so it made me more patient centred particularly as a consultant when you carry the can you know the final responsibility. (929-939)</p> <p>Richard: I'm sure I was a nightmare of a patient I think think it I think it is useful. (957-958)</p>
	<p><b>T2d: The trust between us</b></p>	<p>George: I think you need to have a patients trust first of all that's very important and I think there has to be mutual respect. Once you have earned a patients trust and there is respect and you are polite to each other. (56-58)</p> <p>George: Well I er I mean to some extent I expect the first time when a patient walks in they have never seen you er they they er they expect they they probably come in already biased towards trusting you because we are brought up trusting doctors you know when you are a child if you have a problem you go and see the doctor so that that label of somebody you look up to and trust and you go and speak to them so it's made easy with that but but if you put a patient at ease and you speak to them with respect and you explain things to them, I think communication is key really when you speak to them and you don't treat them as as er condescending really you are not patronising to them er you very quickly earn their trust because they are already halfway there more than halfway there. (111-124)</p> <p>George: I think when you when you get to know a patient a bit more and you see them in for instance dialysis patients that you see in various er you know at various times with various ailments not necessarily related to their renal impairments er over a period of time they develop trust in you and they tell you things that probably don't</p>

		<p>have anything to do with their current problem it's just like when they speak to nurses they get to see lots. (132-140)</p> <p>Christopher: And I really like that aspect of it, the chronicity of the patient under your care who then stays under your care forever and building up that trust with them we go back to that trust thing we started with that there needs to be a mutual trust between them, the doctor and the patient erm that's sometimes easier than others to strike but a really important aspect of the care. (88-94)</p> <p>Christopher: ...they have to er they have to trust that you're going to do what you have said to them in the clinic they've got to trust that you're going to maintain the confidentiality, they have got to trust that you are competent to do what they want want you to do. But there is a, I think there's, it's more important in that direction than us trusting the patient but we still need to need to do that. We need to trust that they're going to come to clinics, that they are going to take their medication, going to have their blood tests when you suggest it and adhere to all whether it's dietary or smoking or whatever, adhere to what we say. I say it's less important because if the patient says they are going to give up smoking by the next time you see them, the doctor-patient relationship hasn't broken down but they have to trust that you're nagging them for the right reasons and not just being belligerent for the sake of it but explaining to them why you want them to stop smoking, why you want them to take this particular tablet so you need to erm justify your decisions in order to build up their trust. (170-188)</p> <p>Christopher: Erm I think there's a, I think we start out with an assumption of trust, because we have got no reason not to. We're, you know the way I see it is that what I am doing in the clinic, or on the ward is for their benefit. It's quite a pompous way to say it but I think you know that it is, and I assume that the patient thinks that it is, and so therefore assume that they would trust me. And I think that that's a good place to</p>
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		<p>start from. (247-254)</p> <p>Christopher: Erm there are times when it becomes apparent that they are not complying with the medication erm or not complying with their fluid balances or and even, we said about smoking, even that I don't think is a huge breach of trust. It's my responsibility then to find out why that is and explain why I want them to do what I've asked them and then if it gets breeched then on numerous occasions, like you say I really need you to do this for this reason then you sort of find that there is a break down in trust. But even even then you still erm (pause) I don't think you, I don't think that affects the relationship as as much. I think you sort of acknowledge, it doesn't affect the relationship as much because at the end of the day it their health that's being compromised. (254-267)</p> <p>Christopher: The places where it can affect the relationship from our point of view are for example if we have given them a treatment such as a kidney transplant, and they have breached the trust by not adhering the the medication so the transplant fails. That has an impact on the doctor-patient relationship because, not because its affected their health and the transplant has failed and they are back on dialysis but because we get frustrated that if we had known that from the start it's such a precious resource, it's a community resource, we could have given it to someone else who was gunna take their tablets. So that I think is the sort of time when erm the doctor patient relationship can break down from a trust point of view from the from the patients side. (267-280)</p> <p>Philip: So in a sense you have got that different thing for the patient and the reason for doing that is someone told me years ago, a friend of mine who used to sell cars he said well first thing as a salesman is you sell yourself and if you don't sell yourself then people won't trust you and if they don't trust you then they won't follow what you are saying and that's that. (148-154)</p>
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Philip: Er it is about selling yourself, selling your trust and the relationship because you make incredible decisions I mean you come and see me as a patient and you have to trust me that I know that this disease this is how you treat it because you are not going to have the experience and things like that and know what to do and things like that erm you know especially with things like surgery, dialysis or something like that. You know god I've gotta trust this guy, I know I don't feel very well but I have got to trust him that he knows what he's doing (laughs slightly). So that is part of the process things like that. (158-168)

Philip: So you have to trust the patient and things like that but obviously it is it is that side of things it has to be positive that they are telling the truth that they are the right symptoms and that they are being honest with you. (217-220)

Richard: I think it's more important that you can communicate with patients and explain problems and get their trust and when they trust you, you've got 50% of your power as I said earlier 50% of what we do is placebo so if they don't like you or don't trust you or they don't like you because they don't trust you then you are just chopping off half your power erm so it just makes you a more ineffective doctor... (171-178)

Richard: (Discussing most important things in the doctor-patient relationship) I think mainly that the patient trusts you. I think firstly that they trust you ethically that you are not going to discuss their care with anybody. They should also trust you that you are not going to share data in any other form cyber data paper data with anybody except on a need to know basis and you'll put relevant checks and balances in place to protect their data, I think that's part of trust. And that you will take their problem seriously even if it doesn't seem that serious to you, I mean if it's a problem to them it's a problem. Erm I think that they have every right to expect that the trust relationship is also based on your own ability to cover up your own belief system.

		<p>(214-225)</p> <p>Richard: (Speaking about when a patient complains) Well you know you stop trusting them. A patient did this to me recently, a patient who is a magistrate whose very articulate and he was annoyed about his appointment, it was, you know, half an hour late, sure it was bad and it was perfectly reasonable to complain about it but you know do you have to write a letter to the chief executive (laughs). (327-342)</p>
	<p><b>T2e: Patient affection is important</b></p>	<p>Alan: ...I mean I was away for about 4 months and the patients who have come to see me when I was not there and they say "<i>Oh where have you been?</i>" and "<i>We've heard you have not been very well</i>" and "<i>I'm glad that you are back</i>" and without exception, even today I've had a patient who was very very complimentary... (164-170)</p> <p>Brian: If if the bit I liked was that she knew she could rely on me. (835)</p> <p>Michael: You know you get on with some of them as friends and some of them are nice and supportive and erm there are a group of them will say "<i>how are you doing?</i>" before you can ask how are they doing (laughs) and even though if that's only in self-interest they are still very supportive and a few of them are friends in a sense you know I have been to the odd wedding and so on but that's a sort of trivial part of the overall thing. (221-228)</p> <p>George: It's important well I don't know I like to I like to talk to people. So my consultations my clinics often overrun unfortunately because I talk to people more than I should and they talk to me more than they should but what I realised is that when they are waiting outside they are not so happy if they have to wait an extra half an hour but when they get in they don't want to get out they don't want to go they want to sit there and talk about things and sometimes I think is this you know there's a cue outside I and they don't want to leave and when the next guy comes in from</p>

outside he doesn't want to leave. (402-412)

Alan: Then when you get them better they start to have confidence in you and they will probably want to see you again and again if there are two of three doctors for example working in the clinic they probably will ask for you specifically to be seen, and if another doctor is seeing them sometimes it ends not well and it happens both ways, some are quite happy to see me while they are seen by somebody else, it differs. (46-53)

Brian: I like to be liked we all do. I like my patients to thank me...(788-789)

Brian: I think most people would want a a doctor who shows that he's confident in the advice he's giving erm not least because it's more likely to work and so yeah I mean you shouldn't we shouldn't underestimate how much I like to be liked, respected and valued and er and for people to think of me with affection you know I I value that and I know that some of my erm behaviour patterns and I think maybe I am thinking more with colleagues rather than patients but probably it extends to patients, are not er terribly endearing. (891-900)

Philip: (Discussing how his patients don't like to leave him) Then open the door and then they are still sat there and then I am really (laughs) it hasn't happened, it doesn't happen very often that someone is still sat there but yeah its lovely. (606-609)

George: I think this patient genuinely likes me because his face lights up with a smile every time he sees me, I might be wrong but I think he does and and he he trusts me because he is now going to start dialysis soon because of what I said and we talk about other things you know last time he was in we were talking about know the Isle of White a holiday he had and this and that how many times he did this and that which had nothing to do with his medical problem really but I get to know him as a

		<p>person. (391-400)</p> <p>George: I'd like to think that they like me but that's everybody everybody likes to be liked, well some people don't care but yeah I don't know, I really don't know. (444-456)</p> <p>George: I get I get feedback sometimes from nurses the specialist nurses and they say 'Oh the patients really like you' once in a while and that feels good but I don't know you will have to ask the patient. (448-451)</p> <p>George: So erm, I like being friendly I like people liking me I like to be liked I think. (521-522)</p> <p>Richard: Erm I think I have a marmite quality as a doctor love him or hate him and certainly some patients keep well clear of me. But I think they tend to like me that I'm chatty and approachable that er reliable and respond hopefully that when I know them and certainly not on the first 3 or 4 visits but when I know them over time they like that I'm a bit of a joker and tease them a bit and they tease me. (839-846)</p>
<p><b>Theme 3: Coping with the job</b></p>	<p><b>T3a: Emotional detachment</b></p>	<p>Alan: I think I am quite good at I leave my worries and problems with regards to work at work. I don't take it at home er I think only time when I might take things home is if there is a real acute problem or acute emergency on the ward which I have to deal with. (149-153)</p> <p>Alan:... and then also those patients who you have known for a very long time and a lot of these patients over the years have died especially the young ones I just find it difficult, difficult to see how you know how such a young person would die. But again I think you have to be really out of this circle of emotionally attached to them and I think, I don't think I have ever been too much emotionally involved with any of our my patients to carry it the next day. (246-253)</p>

Alan: There are patients with which you will always worry but I think if someone is being rather abusive I might feel bad for about a day or so but after that I don't worry too much about it it's just er job.(153-156)

Alan: Erm I think it's I mean personally speaking I I don't emotionally and mentally I don't find that I have that kind of emotional connection with my patients. Erm I owe them as much as I can treat them beyond it I don't think that that's my boundary to step into that boundary and really really that's the fact that they are not my friends I I don't know them outside their medical problems. I might know them a bit more about their social side history but I have no control over what they have done or what they do in their social life. So somehow that connection, I don't I don' make that connection. (Pause) Er and whether that's a way of protecting myself or that's how I protect myself, maybe that's right err I just do not find that I get inside that circle where you become more of their friend or a colleague rather than a doctor. (282-295)

Alan: You're more you're more kind of trying to preserve their respect and their dignity and from that point of view maybe change but I don't think there's a there's any other, but I don't tend to get too emotionally involved with them whenever they are on the ward and I may speak to their family a bit more and perhaps a bit more to the patient and spend a bit more time generally speaking I try to avoid getting too emotionally involved and I think that that's probably the right approach as well at least from, because they don't expect you to be a family member , they don't expect you to be a friend, they expect you to be a doctor and look after them and that's what you should deliver. (265-276)

Brian: (Discussing difficult situations at work) I mean I don't want to sound too callous about it but you can't afford to let it happen, you can't afford to let it get to you. (601-603)

		<p>George: Erm I obviously like everybody else I it's a survival instinct and you protect yourself and stop thinking about it otherwise we burnout. (218-220)</p> <p>George: I mean you see I was telling my family the other day that often as junior doctors you would be involved with resuscitating patients er you are called to cardiac arrest and you do spend an hour there trying to resuscitate a patient it fails the patient dies and its lunch time you go and have lunch and talk about something else who won the football. But if you didn't be able to do the job. (226-232)</p> <p>Brian: And I can very quickly, having identified where there is a problem, where the problem was, or if you made a call, making the wrong call, or whatever, having worked out what happened I can very easily, I don't don't, that wouldn't keep me awake at night. Not in the slightest. It's a job we do our best you know we are not careful careless, bad stuff happens. (595-601)</p> <p>Brian: Oh I'm pretty quick to rationalise it and recognise that we live in an imperfect world. (567-568)</p> <p>Brian: It's a job we do our best you know we are not careful careless, bad stuff happens. (600-601)</p> <p>Brian. I don't, I really don't mind if I've got a case and I make a diagnosis based on the evidence in front of me and its wrong and I recommend something and it goes badly I, I don't mind at all . I don't mind if I have done the best I could, and sometimes it goes badly. (511-515)</p> <p>Richard: I suppose it's mainly in transplant although we also have similar sort of issues with stopping dialysis in the elderly you have the same sort of issues of death but in that way you are sort of causing death or accelerating death and that you know.</p>
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	<p><b>T3b: Positive reframing</b></p>	<p>Actually that that aspect of it that's never bothered me that much. (717-724)</p> <p>Brian: He just didn't have the information erm he could have known, because it was quite an unusual condition, that he should of asked me and I could see and it was a good learning, so that one patient suffered but I'm pretty confident that many more gained when he realised that he was fallible, which I think up to that point he wasn't quite so aware of (Laughs) So that's an interesting point, when things have gone badly, as long as that is used as a as a learning experience the that's life. (545-553).</p> <p>Brian: Things do go badly, we don't always get it right but if we can salvage a good learning point for others to apply to the rest, you know then that experience may have worked beneficially for the next 20 or 30 or 40 years anyway. That's a small price to pay for one patient to suffer, unintentionally, if in fact a learning point is made for over a 30 or 40 year career. So you often get a consolation when things have gone badly about what you rescue from that. (553-561)</p> <p>Christopher: So yeah I think the hardest times are the sort of breaking bad news scenarios but I don't think they're I don't think that's a problem with the doctor-patient relationship at all and if anything can strengthen it and if anything even though it's a hard thing to do again its quite a rewarding part of the job as well because it's something that is very hard to do well and I think if you come away thinking that parted bad news but in a good way that can be quite a rewarding feeling. (669-677)</p> <p>Michael: ...but I think things going wrong makes a big difference. So you don't learn a lot from your successes necessarily but you learn a lot from your mistakes. But you learn from things going wrong. (433-435)</p> <p>Philip: Erm yeah and occasionally you do think from time to time why did that turn out so badly but then if its 1 in 100,000 patients you have seen over 15 years then it's not unreasonable thing. (336-339)</p>
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		<p>Philip: So it is there, those are the positives and they far way outweigh the difficult ones, you are talking actually a tiny percentage of the clinical workload, I mean one patient in 15 year is hardly something. (455-459)</p> <p>Brian: The good is, we do harm and we do good all the time. Every time we prescribe a medication it might cause harm, it's more likely to cause good. So in over the 20 odd year period as a consultant, I've done stuff that worked out well I've done stuff that worked out really really well, I've done stuff that worked out badly. All I need is for that balance to be right. (779-785)</p>
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