Affective Disposition and Patient Fidelity in Relationships with Healthcare Practitioners: A Pilot Qualitative Study in Clinical Communication and Healthcare Trust

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Abstract

Background. Transformation from 'fee for service' provision by practitioners towards bespoke and holistic wellness management is underway. Precision or personalised medicine is the building block for this framework, and rewarded by performance incentive rebates for better outcomes.

Objective. Semi-structured interviews with students and professionals, who are all advantaged by achievement of a healthcare degree, exploring both protocol driven and collaborative experiences with their doctors.

Design. This report is derived from four interviews regarding the patient role in a population of high health literacy. Thematic analysis of patient personality aspects may give new insights into the clinical relationship.

Results. A high level of disposition self-awareness was shown, and these aligned to their recalled situations of conflict. Each of the participants had experienced conditions demanding of close cooperation from their doctor, which wasn't always forthcoming.

Conclusions. Authoritarian treatment plans seemed barely cognisant of patient persona. Tensions in the practitioner's clinic are worthy of further inquiry.

Why this investigation is warranted

Conflict is predicated on disagreement. This idea of both parties having failed when care plan consensus isn't achieved is of interest in the coming era of personalised medicine. Doctor-shopping is unhelpful to both a practice's ability to retain clients, as well as tiresome to health consumers seeking to be heard. Qualitative research gives voice to the consumer.

An inceptual program in Australia is regionally underway, for transformation of primary care from service providers to outcome-rewarded managers of chronic illness and requisite pathways of care (1). Designating GPs to host your Health Care Home has financial incentive in this pilot, but science is also opening up personal medicine through affordable Whole Genome Sequencing, and patients informed by epigenetic notions are online in forums discussing expression of genes by methylation. A subset genotype of 1/60th the genome is being collected for Obama's Precision Medicine initiative, focusing on potential for disease prevention by empowering patients (2). Integrated levels of care is

envisaged (3), however genotyping patients with obscure conditions can expedite specialist help (4), thus redressing the practitioner's exclusivity as oracle.

A redefining of 'health' that incorporates wellness, prevention, and interventions having lesser adverse effects is sought (2), and the examination of 'recovery' as a concept is well suited to qualitative research. The semantics of healing is best shown in the seemingly incurable disease of fibromyalgia, where a phenomenology report shows that recovery can be achieved by deciding it to be so (5).

How then, is the practitioner to change from protocols determined by phenotype, to a schema of Personalised Medicine? This report is predictive of problems that may arise as a hitherto authoritative doctor's dictum takes second place to collaboration with their client as an informed partner. The opportunity is availed of studying this dynamic in a population of high health literacy where all informants have graduated in health science, a known factor influencing the decision-making role (6). Yet meta-analysis of 220 papers reported such ability to research their conditions had a minimal r=0.14 correlation with adherence to treatment plan (7), hence other explanations for disengagement are of interest. Social Determinants of Health (income, age, gender, ethnicity) and health status were even less influential. Attitudes to authority that arise from cultural values was noted as receiving surprisingly little attention, and those resultant from persona received none at all in the literature.

Meta-analysis of 44 papers determined that the mismatch between patient preference for participation in decision making and actuality is an incongruous 40%, regardless of factors of youth and education (8). However patient loyalty is enforced by the difficulty of transferring to another clinic, since despite an $AUD60,000 incentive the uptake of the portable myHealthRecord is abysmal (9).

Methodology

Whether feminist or critical theory has been followed is moot – the limited timeframe and wholly female initial recruitment precluded adjustment for gender. Suffice to say that discourse sought to probe factors influencing the power imbalance when dealing with authoritative figures. The study is neither inductive, nor deductive. No idea is able to be proven in such a small cohort, and all concepts are derived from the literature. No pretension to mixed-methods analysis of associations is claimed, however attitudes are compared on the basis of age.

Situations revealed are probably atypical, the memorable moments. Such outliers in patient care matter nonetheless, since any one of these crises may well have been the informant's last. The all-

inclusive criteria for volunteers of ‘anyone who’s visited a doctor more than once’ was intended to minimise drawing out those with an agenda or ‘bone to pick’. Of necessity, only one side’s perspective was sought. Suffice to say that patient’s failures to adopt protective behaviours (10) is a continued source of disappointment to doctors, as are the ‘worried well’ draining healthcare budgets (11).

Probing of intimate details is akin to clinical privileges. The researcher’s mantle of responsibility is worn as a doctor would their trademark stethoscope, swearing to do no harm but nonetheless intruding into personal space of vulnerable people. To facilitate familiarity, two ruses were applied in order to unveil persona. Informants were asked what character traits were said to be attributed to their starsign. Introspection from this novel inroad may well have substantive basis, since an RCT of aspirin on 17,187 participants after heart attacks found significant negative outcomes for two of the twelve (12). It’s not illogical that a typecast applied from birth influences disposition, hence mind and body interaction. Even US President Reagan admitted to following horoscopes, perhaps to appease the First Lady (13), or superstition consequent to his surviving an assassination attempt, or even a genuine belief. Whether by birthdate, or Ayurvedic’s three ‘doshas’, or genotyping, or other profiling, practitioner cognisance of the patient’s uniqueness is vital.

The second insight was gleaned from preference for Beatles, or Stones. This analogy opens up conversation about loyalty to doctor(s) or clinic, as fan of either a single performer or to the band. Thus post-modern imagery is useful in both presentation of findings, as well as here, in requisite inquiry of meanings attached to relations (14). The intent is to move from superficial pigeon-holing, onto opening of inner doors.

Ethics approval was granted by Deakin through A/Prof Liz Hoban under strict conditions. Nothing that belonged in a medical record was captured, and notice given prior to interview that any mention of specific diseases would be struck. Volunteer participants were Health Science graduates undertaking Qualitative Study HSH715, hence holding a high level of health literacy.

There is risk is that loosely structured questions may wander closer to therapy, such as Motivational Interviewing of an informant’s confidence to select either one of ‘two futures’ in a condition, leading to: “What holds you back from an answer of ‘Extremely so’?” (15), but inevitably observation does alter the observed. To minimise this risk, an even balance of open and closed questions was selected – see Appendix. Answering the former can be awkward when the third party is a physician out of deference to power imbalance. A survey of such relationships had 76.7% respond to a categorical choice for “*What has the care of the family doctor been like*?”, but only 64.5% answered the open “*explain your opinion of your family doctor*?” The two answers were contradictory in 7.5% (16), so

both avenues of inquiry were chosen to gain deeper narratives. Closed questions hold another risk in that the interviewer unduly steered respondents, however they pragmatically suited tight time limits.

Results

One interview's recording was defective. This was repeated, however came out at half-duration, answers becoming more concise and pointed. Another half-length resulted from a first-time meeting, for which the interviewer's discomfort was apparent in an excess of own narrative. The other two came in at a few seconds off the planned 25mins, in which ~2100 words were each contributed by the informants.

A brief content analysis of data is informative. All interviewees were female, two being yet to settle down, and one with young family, and another with grandchildren. A maturity continuum is apparent across several aggregated themes. Own desires were manifest more than half as often again in older respondents than in younger. That ratio was reversed for the younger pair in the themes of both support sought and aggregate of self-aware reflection & amenability to evolve. Introversion and indecisiveness as predicted by recalled starsign traits corresponded to themes expressed by the more youthful two. Likewise assuredness and extroversion were hallmarks claimed by the other two, perhaps demonstrating maturity as a filtering lens they've applied to horoscopes and validating the ruse.

Delving into notions of loyalty were more difficult. Answers to the analogy of preference for one musician versus following the whole band had no correlation with opting for any, or one doctor at their clinic. Each of our informants alluded to experiencing some major, undisclosed health crisis. All persisted with a single provider, whether to jointly resolved consensus or to eventual impasse. A health literate patient may only access the GP as service provider for script, whereas unwavering commitment could be speculated as associating with greater adherence to treatment plan in cases of more serious illness. Surprisingly, it has been shown that only cardiovascular disease had any bearing on obedient trust of physicians (7), which goes partway toward explaining obsessions with unproven or maverick therapies in life-threatening disease (17).

Many themes emerged, but the following seven were prevalent. The first was drawn from the topic itself, patient expectations from the consultation. The next to emerge were contrasts in actuality, followed by ideas of consensus. Final axial coding then sought all themes that cut across the preponderance of data.

Discussion

1. Desires. 'I want' infers a position, either ambit or immutable, that is taken into the consultation. Self-doubt over entitlement to be heard was expressed by QK: "*I shouldn't be asking for all this but I like to have all the information so that I can talk about it with my medical family and not go in to them looking like an idiot*". The greatest proportion of assertive request themes was by the eldest, HB, for whom it paid dividends through expedited diagnosis: "*nothing I said was wrong and I could say, just for example ... I used to have a constant um sniffily nose, which seems a silly thing to talk about but as it turned out that was all part of it*".

2. Decrees. 'They said' is how the patient hears uncompromising, spouted opinion. Bedside manner mattered for LI: "*the CAM provider recommended a different course of treatment then that kind of wrecked our relationship because he was assertive about it*", but conversely NN said: "*if someone, a medical professional is suggesting whatever treatment it is and they don't sound sure about themselves that makes me doubt the whole thing. So delivery is really important*".

3. Conflict. Inevitably, this situation arises where two intractable ideas persist. One consequence will be distancing, as in NN: "*I found that our opinions didn't really match, her advice, I kind of walked away thinking 'nahh, not too happy with that'*." Resolution was eventually found by HB, after a bad start: "*Initially the reality is very hard to hear and you become very defensive. Um, the first time I met with my doctor she told me I wouldn't be going back to my job again. It was my career that I'd built for over 20 years so yeah, I was pretty annoyed…* ".

Conformance could have been selected as thematic due to the prevalence of compliance purely out of respect for the authority. This was cultural for NN: "*In Russian culture if you question someone who is older than you whether that's your parents, your grandparents, teachers, doctors it's seen as a huge sign of disrespect so I think culturally that kind of stuck with me because I'm very aware of that*." Reluctance to challenge authority, leading to passive discontent and a disconnect was declared by QK: "*my doctor's somewhat highly sought after, she always seems to be booked up, so it is very consciously in my mind like, ... She gets to go home after this, I better make this quick, and get out of here and get on with my life*".

4. Consensus. Collaboration arises either when the patient is no longer cornered but given options with varying appeal. Or else one party's position relents, and when it's the patient who adapts, this is explored later on in 'evolution'. NN explains the former: "*…he was like 'look: you have option A and B and C and D, and these are the potential side-effects, these are the benefits. All the pros and cons, at the end of the day it's up to you and I felt like, just finishing his whole speech with "it's up to*

you", makes a really big impact on how I felt afterwards, because I felt empowered to make the choice."

A sanguine outlook plays down the severity of disagreement for LI: "*not intense conflict or anything like that I'm not that kind of person and most doctors aren't, but occasionally we will butt heads... around treatment options, not agreeing with the doctor and not, and not going to follow, and they're not being that happy about it but I was comfortable with that*." The delight in non-judgemental collaboration was apparent for HB: "I*t took some time to manage my condition, and I remember each ahh consultation I had with her I would be talking like there's an expression "word vomit". I would just um, tell her everything I was feeling like as in what was going on in my body um everything and she would just, she wouldn't even look at me, she would sit with pen to paper and listen to everything I was saying and now and again she makes notes. ... my condition is really quite complex so it was a real jigsaw puzzle … it was a real puzzle to put together so she did that really effectively*."

5. Reflection. Self-awareness was revealed in several ways – through metacognition, or alignment to prototypal traits from starsign, or known character profilings such as DISC. The latter determined HB to be an abstract thinker, which she describes thus: "*I think more than anything um I am about that's um I'm highly sensitive to my surroundings, so if I'm in a group of people such as a family situation I can actually feel and am very aware of um discomfort in other people.*" LI determined from her Myers-Briggs ENFP [Extrovert, Intuitive, Feeling, Perceptive] that gave her: "*confidence in your own decision-making, and feeling that you can be the best person the best judge of things yourself*".

The younger two were equivocal. QK worked in a setting that required her to break out of what she saw as an introverted nature. "*I am very extroverted apparently so I've been told I don't see it*". She belittled her own healthcare degree when compared to her doctor's lengthy experience, yet begrudged their old-school, '*stick-in-the-mud*' approach. NN recognised that they contributed to dysfunction: "*I just feel like as soon as there is that effect of power involved or that authoritarian relationship, I feel like I shutdown in that situation and I just don't respond to it."*

6. Support. The lack of social support is a barrier to adherence to treatment plans (7). This situation contrasted, all declaring affirmative others - if not family, then workplace. QK: "*over the lunch table people go 'I saw an alternative therapist and, I had those exact same problems' and then they recommended I do this... checked around for anyone who knows anyone who's been treated the same way whether it's worked*".

Advocacy was required before NN felt heard: "*My dad was furious as well so next time I went, my dad came with me and pushed for further referrals and further investigations. It shouldn't be that way, people should be comfortable to go to their doctors and say 'I'm experiencing this, this 'n this'*".

7. Evolved. Time heals all wounds, but more's the pity is that it mostly worsens chronic ailments. The 'Stages of Grieving Model' is relevant and has been adapted to mindfulness (18), notably so because HB is an accredited Breathworks © Mindfulness for Health (19) teacher: "…*meditation and gaining an increased awareness of um my bodily sensations, and my reactions to those sensations um have been pivotal to move me forward*." A question seeking preference for either of promised results or else empirical performance brought forth mixed, contradictory feelings from LI: "*I'm definitely probably inclined to trust on promise because I trust my intuition to judge the person, rather than looking for evidence, track record. So an assessment based on my experience of that person and what they're committing to.*"

This is another articulation of the 'bedside manner' that underpinned NN's distrust when their doctor's remedy was delivered as an authoritarian decree. Patient online communities are examining this closely (20), but the key factor in a relationship is mutual respect. When it mattered most, it was wanting. NN: "…*it just made me so angry because he didn't know [], firstly. And secondly I just found that quite belittling in a way. Like I'm coming to you with a problem because it's disrupting my daily functioning*…"

Conclusion

Further study on clinic allegiance, perhaps using the workplace predictive model of Exit Voice Loyalty Neglect instrument as applied to academia (21), is warranted on practice clients. This pilot study revealed concepts worthy of further inquiry beyond the ethical boundary precluding mention of specific illness. Nonetheless unfiltered perspectives on the clinical relationship have added to our understanding. Unlike the inconsistently moderated, anonymous complaints on websites, interviews are subject to scrutiny and interrogation for detail. This has permitted delving into aspects of personality that may contribute to greater disconnect between authoritarian practitioners and bespoke personalised medicine. It is questionable as to whether the GP currently has the resource to undertake the task of transforming the primary care model from service provider to wellness management.

Dedication and Disclosures

These are mere words attempting to convey the meanings in richer words, whose giving I am most grateful for. I hope that I've done you justice.

This article in its entirety was provided to all participants for member checking. The author and interviewer independently advocates for sufferers from poorly understood syndromes at website FnMyalgia.com

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Appendix: Interview Guide

Setting scene: You are on a roadtrip, with one CD. Beatles or Stones?

And is that about the music, or musician? [This is the premis I'm working on, how choices are prioritised between preference for the treatment plans, or the Doctor delivering such]

Do you attend more than 1 clinic? [If N] *Do you request any Dr on duty, or schedule with one?*

What do you consider to be factors influencing ownership of health, eg Health Literacy, or age?

Would you prefer to trust on a promise of benefit, or rely upon past performance?

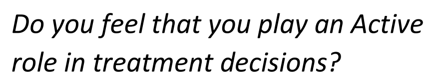
What's your starsign, and do you know what character traits are associated?

Is there another categorization that you may use, eg Ayurvedic dosha, DISC/MBTI profile etc?

A question from the HR dept: tell me about your weaknesses…

What sort of medical advice has influenced you: positively, to comply?

: negatively, to either seek a 2nd opinion or defer action?



[If Y] *In what circumstances has the relationship with your Dr ever been conflicted?*

Would they be kept informed if you decided to try a naturopathic or CAM therapy, on the side?

[If N] *What effect does that have on compliance with advice?*

*Does your Dr treat per protocol, or towards some shared notion of wellness? [*eg statins are provided to >50s, but reduce vitality*]*

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