General Practitioners Have Feelings Too
The Lived Experience of Antibiotic Prescribing in a Group of Male General Medical Practitioners

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Acknowledgements

I dedicate my thesis to my Mum, who I lost during this journey and to my son, whose grit and self-determination were inspirational. He drove me on when I needed to find strength and he helped me make sense of the nonsensical. I thank my family for the support they have given me and for their constant faith that I could make it to the end.

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I would like to thank my work colleagues, particularly Bonnie and Rebecca, who have endured most of my journey with me and offered tea and sympathy during periods of extreme challenge and turbulent times within the NHS.

Lastly but not least, I wish to thank the general practitioners who took part in this study. Their participation, openness, transparency, and honesty allowed me to share with you the reader, a true insight into their living world of antibiotic prescribing.
Statement of Originality

This thesis and the work to which it refers are the result of my own efforts. Any ideas, data, images, or text resulting from the work of others, published and unpublished, is fully identified as such within the work and attributed to the originator, either in the reference list or the footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification.

Carol Cassam

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Abstract

Thousands of medical prescriptions are generated everyday by general practitioners (GPs) and one of the most frequently prescribed groups of medicines is antibiotic therapy (Duerden et al. 2011). Despite the many studies that have previously explored clinical decision making, there remains a lack of understanding about how GPs make clinical prescribing decisions. This study was undertaken because the lived experience in clinical decision making has not been widely studied and there is a gap in the literature.

This study is the first of its kind to use a phenomenological approach to explore the lived experience and emotional side of antibiotic prescribing in the context of medical prescribing.

The aim of this study was to explore, interpret, and understand the lived experience of antibiotic prescribing in general practice.

To explore the lived experience of antibiotic prescribing, I used the methodological framework of hermeneutic interpretative phenomenology. Unstructured, face-to-face interviews were conducted with ten GP participants. I transcribed the interviews and based the analysis on Kvale’s six steps of data analysis.

Medical prescribing is a complex process based on many factors that include intuitive feelings, clinical knowledge, and professional experience. There are many influences that evoke GPs’ emotions and these emotions then drive the prescribing decision. Influences are both internal, such as the knowledge and experience of the GP and external, such as patients, families, and national policy.

Writing a prescription is one of the most frequent procedures undertaken in general practice, yet it often remains a challenging experience and causes many GPs to feel anxious, uneasy, and sometimes overwhelmed. Behind the confident and composed public face of GPs lies a professional group of clinicians who are caring and empathetic but often feel anxious and vulnerable.

The findings of the study have implications for practice, education and research.

Keywords: GPs, prescribing, decision making, intuitive feelings, phenomenology.
Chapter 1
Introduction

Introduction

This introductory chapter provides an overview of the study and a summary of each chapter within this thesis. I present the importance and impact of this study, my motivation for the chosen topic, and the focus of this study. An overview of the general practice consultation, antibiotic prescribing in the context of medical prescribing, and decision making provides a background and context for the study. Chapter one concludes by outlining the content of chapters two to six.

1.0 Importance of the Study and Original Contribution

This study was important to me because it occurred during a period of radical transformational change within the NHS. All Primary Care Trusts (PCTs) across England were abolished and general practitioner (GP) led Clinical Commissioning Groups (CCGs) were emerging to become the commissioners of local healthcare services and provision\(^1\). This study is significant because no other study has used interpretative phenomenology to explore the emotions and experience of medical prescribing.

This study makes an original contribution in three ways. Firstly, it adds to the body of knowledge, secondly, it contributes to methodology, and thirdly, it makes a theoretical contribution (chapter 6, section 6.1).

\(^1\) Following the 2013 NHS reforms Primary Care Trusts were abolished in March 2013 and replaced with Clinical Commissioning Groups (CCGs), Commissioning Support Units (CSUs) and NHS England.
1.1 Motivation for Choosing the Topic

The motivation for this study came from my desire to understand the lived experience of antibiotic prescribing in the context of medical prescribing as told by the general practitioners themselves.

My background is in community nursing and more specifically district nursing. During my work as a district nursing sister, I became an independent nurse prescriber² trainee and felt privileged to have an inspirational GP mentor and supervisor. On many occasions, I shadowed my mentor and observed the general practice clinical consultation and the interaction between the GP and the patient. I was keen to learn how my mentor made clinical prescribing decisions so quickly and I constantly asked questions, such as why my mentor prescribed for some patients and not others even though the presentation and symptoms appeared similar or the same. To find answers to my countless questions, I visited many practice settings, observed, and listened intently to how different GPs reached the decision to prescribe. What I witnessed during that time was a group of professional clinicians who appeared to be confident and at ease in the clinical consultation setting.

Later as a qualified independent nurse prescriber, I often felt apprehensive and uneasy in my early days of prescribing as I realised the enormity of the new role I had taken on. I recognised my accountability for my prescribing decisions and my confidence grew the more I practiced. Prescribing soon became a natural part of my district nursing role. As a community practice teacher, I mentored and supervised district nursing students and continued to mentor and support them through their nurse prescribing training. Now, many years later as a senior manager in the NHS, my role within healthcare has changed to one of commissioning healthcare services

² Nurses who have successfully completed a Non Medical Prescribing course are independent prescribers. As an Independent prescriber, the nurse is responsible for the initial assessment and diagnostic decision making for a patient (Department of Health 2012).
to improve quality outcomes for patients. My role calls for me to work collaboratively with colleagues from primary care and in particular, those from general practice. I have reflected often on my experience as a clinician and an independent nurse prescriber and have contemplated what it feels like to be a medical prescriber within general practice. I have frequently wondered if the things I witnessed during my trainee days really represented the true lived experience of medical prescribing. Undertaking a doctoral study has provided me with the opportunity to gain a real insight and understanding of the GPs' lived experience of antibiotic prescribing in the context of medical prescribing.

1.2 Focus of the Thesis

The focus of this thesis was therefore to understand the lived experience of antibiotic prescribing in the context of medical prescribing and the emotions involved in the clinical decision process. The lived experience encompasses meanings derived from being in the world (Van Manen 1990). It is essential to discover this meaning to understand truly the experience of medical prescribing. This study focuses on the experience of antibiotic prescribing because very few studies have been undertaken that look at this side of GP prescribing. The purpose of this exploratory phenomenological study was to gain an insight, interpret, and understand the lived experiences as told by the GPs themselves.

1.3 Background

1.3.1 The General Practice Consultation

The background to this study starts with the GP and patient consultation because most general practice prescribing is undertaken within this clinical setting (Pawlikowska et al. 2007). Understanding the concept of the clinical consultation supports understanding of the GP and patient dynamic (Bradley 1992). On average
patients consult with their GP approximately 5.5 times per year (Duerden et al. 2011). The general practice consultation brings together two expert parties, one being the GP, who has the clinical skills, knowledge, and expertise to diagnose and treat medical conditions; and the other the patient, who has the experience and expertise of their own ill health (Tucket et al. 1985).

Over the years, there have been many different approaches to the general practice consultation and as such, a variety of consultation models exist. For example, Improving Communication (Weiner 1948), Hierarchy of Needs (Maslow 1954), Bio Psychosocial (Balint 1964), Theory Model (Berne 1964), Research Based in General Practice (Byrne and Long 1976), and Theoretical Framework (Stott and Davis 1979). Helman (1984), Pendleton et al. (1984) and Neighbour (1987) have produced examples of the Patient Centered Consultation models. The various consultation models provide a framework to support the GP to interpret and understand the patient’s experience but no one model is perfect and all will have strengths and weaknesses (Pawlikowska et al. 2007). However, there is no determined right or wrong way to undertake a clinical consultation and the different models provide a structure to support interactions between the GP and the patient. The consultation models provide a script to help guide the GP but they are not a rigid set of rules or instructions (Bevington 1990). Each GP develops his/her own consultation style and adopts different components of the models to form an eclectic model, which is both individual and exclusive to them (Pawlikowska et al. 2007). Each consultation is unique, with the GP varying their approach according to both their situation and the patient needs.

Some consultation styles are more effective than others depending on both the GP and the circumstances of the consultation. Mishler (1986) argues that GPs who
follow a patient-centred consultation approach are more flexible in responding to the circumstances of the consultation and the differing needs of their patients than those who follow a more doctor centred style. The consultation should support effective communication that allows the GP to establish a rapport with the patient (Silverman et al. 1998) and there should be a shared decision making approach between the GP and the patient when managing the patient’s problem. Over recent years, there has been greater emphasis placed on GPs addressing patient expectation by consulting in a more patient centred way (Department of Health 2010). While this concept is far from new, it may not always translate into practice (McWhinney 1985). The consultation process is both dynamic and complex because the GP not only brings medical skills and knowledge to the consultation but also a wealth of experience, both professional and personal, which s/he should be aware of and consider when listening to and managing the patient (McWhinney 1985, Bradley 1991). These skills support the GP when making prescribing decisions (Kushner 1981, McWhinney 1985, Bradley 1991).

The focus of the modern NHS is on patient engagement and choice, and practice is based on the concept known as No Decision About Me Without Me (Department of Health 2012). Giving patients more choice about therapeutic interventions may lead to treatments being more effective because patients who understand their treatment are more in control of their care (NHS Choices 2010). Patient choice includes two fundamental rights. Firstly, patients have the right to choose a GP and to change to another if they are not happy with the service received; and secondly, patients have the right to be involved in decisions about their health care, which includes treatment and prescribing decisions (NHS Choices 2010). The general practice consultation provides GPs with the opportunity to empower their patients and involve them in the clinical decisions relating to medical prescribing.
1.3.2 Antibiotic Prescribing in the Context of Medical Prescribing

All general practitioners are qualified to prescribe. Medical prescribing is a fundamental part of the general practice consultation and accounts for approximately fifteen per cent of the NHS budget (Prescribing Support Unit 2010). The number of dispensed medical prescriptions issued in England by general practitioners was 886 million, with a financial cost of 8,359 million pounds sterling (Prescribing Support Unit 2010). Over the last ten years, approximately 40.8 items were prescribed for every patient over the age of sixty, (NHS Information Centre 2010) and approximately two thirds of general practice consultations end with patients receiving a medical prescription (Harris and Dajda 1996). Approximately 1.6 million antibiotic prescriptions are issued needlessly with a financial cost of around 8.4 million pounds sterling. Simpson et al. (2009) argue that while 85-90 percent of antibiotic prescribing occurs in General Practice about fifty percent of such prescriptions are unwarranted. Reducing antibiotic prescribing has obvious financial benefits. Additionally other cost benefits include the reduction of both antimicrobial resistance and antibiotic associated complications such as Clostridium difficile (UK Medicines (2012), suggest antibiotics are the most significant predisposing risk factor for Clostridium difficile among patients) and antibiotic associated diarrhoea. GP consultations may also reduce if patients are not exposed to the side effects of unnecessary antibiotic therapy.

To date, defining high quality prescribing has proved difficult because prescribing is multi-factorial and all the factors that play into prescribing decisions are not always known or fully understood (Duerden et al. 2011). However, to improve the quality, safety, and effectiveness of prescribing, Duerden et al. (2011) suggests that GPs should ask themselves if the prescription is necessary. In addition, GPs should involve the patient when considering the treatment options and discuss the benefits
and risks of the drugs considered with the patient. The GP can then make the prescribing decision.

### 1.3.3 Clinical Decision Making in Prescribing

Decision making has been the subject of many psychological studies over the last thirty to forty years (Hammond 1980, McWhinney 1985, Hamm 1987). I discuss decision making, the dual process theory, and the cognitive continuum in the literature scoping exercise in chapter two of this study (Koch 1996). Here I present an introductory overview of clinical decision making.

Decision making in medicine is a critical skill, yet clinical decision making is not routinely taught in medical school. Instead, trainee doctors often learn decision making from their consultant mentors and clinical supervisors (McWhinney 1985, Bradley 1991, 1992, 1993, Croskerry and Nimmo 2011, Woolley and Kostopoulou 2013). Decision making is the term used for the process of making a choice between options as to a course of action (Smith et al. 2008). However, in general practice, clinical decision making is a complex process that requires more than making defined choices between limited options. To manage the diversity of patient problems, GPs utilise a variety of clinical decision making skills and strategies (discussed in chapter 2, sections 2.1, 2.2, 2.3, 2.4, 2.5,) (Bradley 1991, Smith et al. 2008, Andre et al. 2012). GPs make clinical decisions every day that affect the health of their practice population. Despite the numerous studies that have previously explored clinical decision making, there remains a lack of understanding about how GPs make clinical prescribing decisions, possibly because prescribing decisions are multi-factorial and complex (Bradley 1991, 1992, 1993, Smith et al. 2008).

GPs make many prescribing decisions daily, which may lead to a misconception that
making a prescribing decision is straightforward. Making prescribing decisions is multifaceted because the decision may be influenced by external non-pharmacological factors such as national policy, health care commissioning, and patient expectation (Bradley 1993). Other internal factors may also influence the decision to prescribe and include professional experience, clinical knowledge, intuition, and intuitive feelings (Carthy et al. 2000). Professional experience and clinical knowledge are recognised in the medical world as credible factors for clinical decision making. However, Stolper et al. (2009) and Woolley and Kostopoulou (2013) argue that intuition is not science based and much less is known or understood about this phenomenon. For this reason, reliance on intuition is often seen as unnecessary in the age of evidence-based practice. In order to deliver safe, effective care, quality decision making is essential; therefore the process and factors that affect GPs’ clinical decision making should be explored, interpreted, and understood. This study will help bridge the knowledge gap regarding decision making in medical prescribing because clinical decision making is a fundamental element of the lived experience of antibiotic prescribing.

1.4 Outline of Remaining Chapters

Chapter 2 – Scoping the Literature
I critically discuss the medical literature relating to clinical decision making and explore the role of intuitive feelings. I highlight the gaps and limitations of the literature, which are later addressed in chapter 6, section 6.3.

Chapter 3 – Methodology
I present the principles of the methodological approach and the rationale for my chosen method before discussing other methodological considerations and outlining the study aims and research question. This chapter outlines the research methods,
sample selection, and the ethical considerations for the study. Finally, I describe the face-to-face open-ended interviews as my method of data collection and present the rationale for adopting an eclectic approach to my data analysis, which is loosely based on Kvale’s six steps of data analysis.

**Chapter 4 – Findings**

I present the findings and my interpretation of the data under four main theme headings. Each theme is subdivided into subthemes (section 4.1) and presented with data.

1. Getting the clinical decision right
2. Doing the right thing for patient
3. Managing expectation
4. Managing reputation

**Chapter 5 - Discussion**

From the findings, four key areas emerged which I discuss with the existing literature.

2. The Experience of the Clinical Consultation
3. Influences on Decisions
4. Feeling Clinically Credible

**Chapter 6 - Conclusions**

In this final chapter, I review the extent to which the chosen research methodology has met the aim of the study and answered the research question. I present the unique contribution of this study and present the role emotions play in the prescribing decision. I acknowledge the limitations of this study before proposing the implications
for practice, education and research, summarising the main findings and presenting the conclusions.

Summary

This chapter specified the importance and original contribution of the study. I presented the motivation for the chosen topic and the focus of the study, before providing the background and context of the study. I presented an overview of the general practice consultation, antibiotic prescribing in the context of medical prescribing, and decision making. Finally, I outlined the content of chapters two to six.
Chapter 2
Scoping the Literature

Introduction

Clinical decision making is a fundamental component of prescribing and is therefore
the focus of this literature scoping exercise. In Hermeneutic interpretive
phenomenology, which is the methodology used in this study, a formal or systematic
literature review is not undertaken (Koch 1996). In this chapter, I critically discuss the
literature relating to clinical decision making in medicine, before reviewing the early
work on analytical and intuitive reason and discussing these concepts in light of more
recent literature. I then review both analytical and intuitive decision making and
explore the literature relating to intuition and intuitive feelings. I review the concept of
the expert doctor and professional expertise in decision making and consider the
limited literature on emotions. Finally, I review some of the external influences on
prescribing decisions and present how this study helps to bridge the gap in the
literature.

2.0. The Literature Scoping Exercise

Independent nurse prescribing, though a relatively new phenomenon, is well
researched and evaluated, with many published works by researchers such as
Carey, Courtenay and Stenner (2013), Courtenay and Carey (2007) and Luker
(2002)3. It is perhaps then understandable that as an independent nurse prescriber I
initially turned my attention to the nurse prescribing literature. However, the focus of
this study is medical prescribing and the lived experience of antibiotic prescribing in

3 Following the Cumberlege report (1986), the first nurse prescribing pilots were set up in
1996 with district nurses and health visitors accessing a limited national formulary in 1998.
Nurse prescribing initially made slow progress but is now well established as a mainstream
qualification with over 54,000 nurse and midwife prescribers across the UK. (Royal College of
Nursing (RCN) 2012).

Nurse prescribing improves patient care by ensuring timely access to medicines and
treatment, and provides flexibility for patients who would otherwise need to see a doctor.
the context of medical prescribing. Therefore, I do not intend to scope or include the nursing literature because although pertinent to me as a nurse prescriber, it is different from GP prescribing,\(^4\) so is not applicable to this study. The concept of computer software packages to support and improve the quality of medical decision making is not new and several studies have explored the use of such systems. However, I do not intend to scope or include this literature because it does not focus on general practice and is therefore not relevant to this study.

### 2.1 Analytical and Intuitive Clinical Decision Making

Much of the available literature focuses on the concept and process of decision making and how clinical decisions are made, rather than the experience of decision making. The role of emotions and the lived experience in clinical decision making has not been widely studied and there is a gap in the literature. Studies do exist that explore the decision making process in prescribing. For example the following authors focus on the influences that affect prescribing decisions, McWhinney (1985), Bradley (1991), (1992), (1993), Essex and Healy (1994), Stevenson (1999), Denig et al. (2002), Kumar et al. (2003), Dreyfus (2005), Hyde et al. (2005), Hardy and Smith (2008), Croskerry and Nimmo (2011), Andre et al. (2012). However, these studies are predominantly quantitative and do not explore the lived experience of prescribing. The few qualitative studies found either do not focus on general practice or they did not use phenomenology as the basis of the research methodology (Stevenson 1999, Stolper et al. 2009, Andre et al. 2012, Woolley and Kostopoulou 2013) and therefore the studies do not reflect the lived experience of the research participants.

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\(^4\) Doctors study pharmacology for two years followed by three years of clinical pharmacology learning the drugs and treatment options for particular diagnoses. Doctors are taught to diagnose and prescribe on their findings. (British Medical Association 2012).

Nurse prescribers study the theory of prescribing for a period of 26 days and 12 days of supervised practice, nurses tend to treat and care. (Royal College of Nursing 2012).
Clinical decision making is widely studied because it is undoubtedly one of the most important elements of being a doctor (Croskerry and Nimmo 2011) and as such, various models of decision making exist. However, Croskerry and Nimmo (2011) argue that the dual process theory is one of the most used decision making models. The dual process theory contrasts two systems of decision making. The first being the analytical decision, which is a conscious decision, based on science and reason and the second being the intuitive unconscious decision based on heuristics and non clinical reasoning. Croskerry and Nimmo further argue that intuitive decision making is linked to strong emotions and therefore may lead to an over confidence in the decision or a confirmation bias. Other literature, such as Hammond (1980), Hamm (1987), Stolper et al. (2009), and Stolper et al. (2010), concur with this notion to suggest that unlike analytical decision making, which is a slower, deliberate, and considered process, intuitive decisions are rapid, spontaneous, and reflexive.

While effective decision making is critical for the delivery of high quality safe care, the basis for making clinical decisions is not clear in the literature. McWhinney (1985) argues that decision making in general practice differs from that in other fields of medicine for several reasons. Firstly, GPs often see illness at an earlier stage so there may be fewer patient cues and decisions have to be made at a lower level of probability than in more advanced disease. Secondly, the ethos of general practice is an open-ended relationship between GP and patient. Therefore, McWhinney suggests there is less pressure for GPs to make decisions within a set timeframe because unlike their hospital colleagues, GPs are able to recall the patient and review them over several consultations. McWhinney’s work is suggestive of the early work of Balint (1964), who suggests that GPs should not feel rushed into making clinical decisions so long as there is no immediate risk to the patient. Instead GPs should stop, think, monitor, and review the patient over a series of consultations. If
necessary, GPs should recall the patient. Hardy and Smith (2008) argue that overt and covert information leads the clinician but it is the intuitive feeling linked to the expertise of the clinician that drives the clinical decision. However, Hardy and Smith then question the meaning of intuitive feelings and intuition. While the role of intuitive decision making is discussed within the literature, many studies and papers including those by Hammond (1980), Essex and Healy (1994), Hamm (1987), Stolper et al. (2009), Stolper et al. (2010), and Woolley and Kostopoulou (2013), acknowledge that there is a lack of understanding of the role of intuitive feelings in medicine. Therefore, only by undertaking further research will the concept of intuition and intuitive feelings be understood.⁵

### 2.2 Intuitive Feelings and Intuitive Decision Making

Commonly used terms such as *I have a feeling, it does not feel right, or I just know*, are part of everyday language. How or why people feel such knowing is often referred to as intuition, gut feelings or intuitive feelings (throughout this study I refer to intuitive feelings). However, as there is a lack of understanding within the literature as to the meaning of terms such as intuitive feeling, I would argue that a definitive definition of intuitive feeling within the medical field has yet to be determined. According to the Oxford Dictionaries website (2013), intuition is the ability to acquire knowledge without inference and, or, the use or reason. This definition fits with the notion of intuition as proposed by Croskerry and Norman (2008) and Hardy and Smith (2008). Intuitive feelings are sometimes referred to as tacit knowledge; knowledge built from personal and professional experience, which is known but cannot be articulated or explained.

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⁵ I address this gap in the literature in, chapter 6, section 6.3
In the 1986 paper, *Mind over the Machine*, Dreyfus and Dreyfus argue the concept of intuition and intuitive feeling is not new and has been studied widely within psychology over the last thirty to forty years. However, Dreyfus and Dreyfus conclude that psychological concepts may not fit with medical diagnosis and decision making.

On the concept of intuition in decision making, Dreyfus and Dreyfus also note that people often know something they cannot articulate or explain, yet they feel it. Dreyfus argues that this is intuitive feeling in action. The person immediately knows what to do and how to act and decisions are spontaneous with no other options considered. Dreyfus and Dreyfus (1986) argue that intuitive feelings not only improve decision making but also lead to better outcomes than analytical decisions. However, Dreyfus and Dreyfus acknowledge that the medical literature does not favour intuitive decisions because of the potential for error. This is emphasised by Croskerry and Norman (2008) who explored decision making and the reduction of diagnostic error. Croskerry and Norman conclude that an analytical approach to clinical decision making is required to reduce diagnostic error, because intuitive decisions are less reliable. However, in a qualitative study Stolper et al. (2009) argue that studies exploring the validity and reliability of intuitive decisions are lacking in the medical literature and the role of intuitive feelings remains unclear and not fully understood.

Stolper et al. (2009) used focus groups to explore clinical decision making and concluded that GPs sometimes base their decisions on intuitive feelings alone, even when there is little evidence of their diagnostic or prognostic value. Stolper et al. found that GPs’ intuitive feelings and subsequent decisions, as to the seriousness of chest pain, were highly reliable. Therefore Stolper et al. concluded that intuitive decision making, though often linked to clinical uncertainty, frequently resulted in positive outcomes. Similarly, a qualitative study by Woolley and Kostopoulou (2013), found that physicians use intuitive judgment when they sense that something is not
right. While the intuitive decision sometimes had a negative outcome, Woolley and Kostopoulou also found positive outcomes from such decisions. Therefore, one may conclude that non-analytical decision making should not be dismissed until more is known and understood about the subject. A further paper by Stolper et al. (2009) concurs with the work of Dreyfus (2005) and the notion of intuitive feelings in decision making. Both Stolper et al. and Dreyfus agree that intuitive feelings relate to experience and knowledge and therefore expertise. Dreyfus (2005) argues that intuitive feelings result in fast rapid actions performed without conscious awareness. The basis for the action or decision cannot be spoken or taught to others, yet it is known and felt. Doctors who have participated in some studies have reported a strong feeling in their abdomen and heart. Resnick (2012) argues that such feelings are intuitive.

Hammond (1980) theorised that analytical reasoning and intuition were on a continuum and as such, he developed the cognitive continuum theory. Hammond argues that between the two points of analytical and intuitive, much thought goes on, with intuitive cognition linked to both positive and negative intuitive feelings. Following Hammond, Hamm (1987) argues that most thinking is not purely intuitive or analytical but somewhere in between. Hamm refers to this concept as quasi rationality cognition, a term originally coined by Hammond. Stolper et al. (2009) developed Hammond’s early work of intuitive feelings by applying it to practice. Stolper et al. argued that in the practice situation when faced with diagnostic uncertainty, intuitive feelings are linked to a sense of alarm and the negative feelings that something is wrong, or a sense or reassurance and the positive feelings associated with intuitively knowing there is nothing seriously wrong. However, in a

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6 The cognitive continuum theory developed by Hammond (1980) most likely underpins the later developed dual process theory (Dreyfus 2005).
2011 paper, Croskerry and Norman argue there are blurred lines between intuitive and analytical decisions because one can override the other. For example, analytical reasoning can override intuitive non-reasoning when one needs to consider a situation in more depth and likewise, intuitive reasoning can override analytical reasoning. Though analytically a GP may know what to do, intuitive feeling may be strong enough to cause the GP to override analytical reasoning. However, Croskerry and Norman conclude that intuitive decisions can sometimes be irrational. In contrast, Dreyfus (2005) argues that intuitive feelings are linked to a personalised knowledge which is utilised in a non-analytical way that supports intuitive clinical decision making.

2.3 Professional Experience and Expertise

The literature suggests that Intuitive feelings are often related to professional experience and expertise, with decision making reliant on judgmental expertise; for example, the works of Dreyfus and Dreyfus (1986), Hammond (1980), Hamm (1987), Essex and Healy (1994), Dreyfus (2005), Stolper et al. (2009), (2010), Resnick (2012), and Woolley and Kostopoulou (2013). Kumar et al. (2003) used a grounded theory approach to explore why doctors prescribe antibiotics for sore throats. Kumar et al. found that clinical experience and knowledge were factors for GPs to make an intuitive decision rather than an analytical decision grounded in evidence based medicine. Similarly, in a quantitative study, Dordevic and Jankovic (2002) looked at the characteristics of the decision making process during prescribing. Dordevic and Jankovic found that experienced GPs considered fewer treatment options and prescribed fewer treatments than less experienced GPs. Dordevic and Jankovic argue that contextual and habitual influences affected GP decision making with practical experience having the biggest effect on their prescribing decisions. Likewise, a quantitative study by Denig et al. (2002), used a think aloud approach to
explore the cognitive process of doctors’ decisions on patient treatment. Denig et al. concluded that GPs’ experiences affected the number of choices considered in GP prescribing decisions and GPs’ professional experience outweighed analytical reasoning. Even though the GPs in Denig et al.’s study did not consider all the options available to them, it did not result in poor prescribing decisions. The link between decision making and expertise has also been found in other studies, for example, in a 2008 paper, Reyna proposes that the more options clinicians have to consider the poorer the quality of the decision. Reyna argues this notion is in contrast to the general assumption that more information results in better decision making. Reyna concludes that expert doctors who considered fewer options had better diagnostic outcomes than less experienced doctors who analytically considered more options over a longer period.

A 2008 literature review by Resnick concluded that experts usually use an unconscious intuitive decision process when finding solutions that have worked before in similar clinical situations. Similarly, studies by Bradley (1991), (1992), (1993), argue that a correlation exists between clinical expertise, intuitive decision making, and good decision making outcomes. There is a consensus in the literature that intuition links to expertise (Bradley 1992, 1993, Stolper et al. 2009, Stolper et al. 2010, Reyna 2008); however, the criterion for considering a doctor an expert is not clear in these studies. Woolley and Kostopoulou (2013) argue that psychologists use the ten-year rule, whereby an expert is someone who has practiced for ten years or more. However, while the medical literature frequently uses the term expert, none of the medical literature uses this parameter as a measure of expertise.
Dreyfus and Dreyfus (1986) described a theory of expert cognition and proposed that intuitive feelings and intuitive decision making are linked to expertise and that expertise is achieved by moving through five stages. After starting as a novice, one moves to the second stage and becomes an advanced beginner, before developing competence and skills of proficiency in stages three and four and then finally achieving the status of expert in stage five, whereby one has the knowledge and expertise to make intuitive decisions. The findings of Croskerry's and Nimmo's (2011) decision making study concur with Dreyfus and Dreyfus because Croskerry and Nimmo found that novices and trainees spend more time in the analytical stage of decision making. However, Croskerry and Nimmo argue that repeated presentation to the analytic mode will eventually result in recognition of both problem and solution and intuitive feelings will arise as expertise develops.

Hamm (1987) argues that expert doctors oscillate between using intuitive feelings and analytical reasoning depending on the situation. In contrast, Hamm suggests less experienced doctors only use analytical reasoning because they have yet to develop, recognise, and trust their intuitive feelings. This concurs with the work of Dreyfus and Dreyfus (1986), who found that more experienced physicians reported comparatively more intuitive feelings than those less experienced. Dreyfus and Dreyfus proposed that expertise comes from emotional awareness learned from experiencing one's own success and failures. Dreyfus and Dreyfus argue that choosing to remain detached from one's emotions not only results in failure to become an expert but also failure to develop intuitive feelings and thus failure to become an intuitive decision maker. In a 2009 paper Stolper et al. question whether

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7 The phenomenology of skill acquisition using a five stage approach (Dreyfus and Dreyfus 1986), Dreyfus & Dreyfus argue that decisions made during stages 1-4 (the novice, advanced beginner, competent, and proficient stages) are analytical. Decisions made at stage 5 (expert stage) are intuitive because an expert intuitively knows what to do without applying rules and making judgements.
reflecting on practice may be a way to support GPs to develop their intuitive feelings because current GP training only focuses on analytical reasoning. In a study evaluating a rule base for decision making, Essex and Healy (1994) argue that medical students learn decision making from observation and therefore risk adopting the thought processes of their medical teachers. However, Dreyfus and Dreyfus argue that when forced to articulate their intuitive decision making, experts describe a rationale that they no longer use because they cannot articulate their intuitive feelings in a rational way. In a critical analysis of patient safety practices, Resnick (2012) concurs with others in arguing that experts use an unconscious decision making process related to intuitive feelings. Resnick suggest intuitive feelings and emotions will always be present in decision making because some emotions are personal traits and that doctors make life, death and wellbeing decisions, which often stem from their intuitive feelings and emotions.

2.4 Emotions in Decision Making

The role of emotions in clinical decision making and the emotional attributes of medical prescribing have not been widely studied and there is a gap in the literature. Little is known or understood about the role of emotions in clinical decision making; therefore, there is a need for further investigation. With the exception of Balint et al. (1993), who used the framework of Balint groups to study GPs’ emotions relating to

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8 I address this gap in the literature both in the summary of this chapter and in chapter 6, section 6.3.

9 A Balint group consists of six to twelve doctors with one or two leaders. The group meets regularly with meetings usually lasting for an hour or two. The method is that of case presentation without notes. The case presenter describes what happened between the patient and themselves and how they felt. The group then discusses the relationship between the doctor and patient and tries to understand what is happening that evokes these feelings.
their clinical interventions and Nettleton et al. (2008), whose qualitative study analytically explored the emotional aspects of routine professional medical work very few studies exist. Nettleton et al. explored the emotional response of GPs to various aspects of their everyday work and how they felt. However, the study did not focus on decision making or medical prescribing. The only other work is a literature review by Croskerry and Norman (2008) who argue that three studies examined the role of positive mood on decision making and all concluded that the emotional state of the doctor significantly affects clinical reasoning. However, it is not clear from the literature review which three studies Croskerry and Norman are referring to. Croskerry and Norman acknowledge that further research is required to fully understand the effect of emotions on diagnostic treatment decisions.

2.5 Influences on Prescribing

Much has been written about Clostridium difficile in an attempt to educate clinicians, empower patients and reduce the number of avoidable Clostridium difficile infections. Simpson et al. (2009) trialled and evaluated a social learning theory based program, entitled The STAR Educational Programme to reduce antibiotic prescribing in primary care. However, most of the available literature is quantitative or focuses on the pathophysiology and, or the ranking of antibiotics, according to risk. There were no studies found that explored whether GPs recognise Clostridium difficile as a risk or if Clostridium difficile influences their antibiotic prescribing. This gap in the literature is addressed in chapter 6, section 6.3.1.

The literature suggests that many non-pharmacological influences affect prescribing decisions, for example, Bradley (1991), (1992) (1993), Hyde et al. (2005), Tsiga and Panagopoulou (2013). Bradley (1993) used a focused interview technique to study the process that leads to prescribing decisions. Bradley concluded that both clinical
and social considerations affect clinical decisions, particularly when deciding whether to prescribe or not. Bradley argues that GPs consider social influences, such as the doctor and patient relationship across the full range of clinical problems and associated therapeutic interventions. Similarly, in a 2013 paper Tsiga and Panagopoulou argue that external influences such as the patient and doctor relationship affect decision making. Tsiga and Panagopoulou suggest other external influences such as time pressures affect cognition and result in a more intuitive decision because it is less time consuming, though potentially more risky than an analytical approach. Other studies report similar findings to Bradley and Tsiga Panagopoulou, for example an observational study by Miller et al. (1999) found GPs not only prescribed when faced with clinical uncertainty but that patients greatly influenced their prescribing decisions. Similarly, a quantitative study by Hyde et al. (2005) investigated decision making in antidepressant prescribing, concluding that prescribing decisions were often based on time pressures and perceived patient attitude. A common finding in the literature is that influences such as patient demand and time pressures affect prescribing decisions, for example Bradley (1991), (1992), (1993), Miller et al. (1999), Stevenson (1999), Carthy et al. (2000), Denig et al. (2002). In a qualitative study Carthy et al. (2000) argue that despite an abundance of literature, there remains a lack of understanding as to the factors that affect prescribing decisions because even though patient demand and time pressures are commonly cited it is not understood how or why they affect decision making.

2.6 The Gap in the literature

Scoping the literature has exposed some gaps. For example, there were no studies found that investigated whether the risk of Clostridium difficile influenced antibiotic prescribing. Additionally no studies were found that used a phenomenological methodology or focused on the lived experience of antibiotic prescribing in general
practice. This is justification for undertaking this study. While other studies have explored the decision making process and the influences on prescribing, the majority use a quantitative research design. Few studies exist that focus on the emotions of GPs in relation to decision making and none have explored emotions in relation to medical prescribing. This phenomenological interpretive study seeks to provide an understanding of how it feels to be a medical prescriber and therefore helps to bridge the gap in the literature because no other study has researched medical prescribing in this way.

**Summary**

I presented a scoping of the literature relating to clinical decision making in medicine which is congruent with the methodological approach used in this study (Koch 1995). After reviewing the early work of analytical and intuitive reason, I discussed these concepts in light of studies that are more recent. Analytical and intuitive decision making were discussed and the literature relating to intuitive feelings explored. The concept of the expert doctor and professional expertise in decision making were reviewed before considering the limited literature on emotions in medical decision making. Finally I presented how this study will help to bridge the gap in the literature and argued that no other studies explored the lived experience of antibiotic prescribing or used phenomenology as their research methodology.
Chapter 3
Methodology

Introduction

In this chapter, the concept of phenomenology and the work of Edmund Husserl and Martin Heidegger will be explored. I present the aim of the study and the research question before describing the research methods. This is followed by a description of the ethical considerations, the method of data collection, data analysis, and the Hermeneutic cycle. Finally, the approach for data management and issues of rigour, validity, and credibility of the study are considered.

Antibiotic prescribing in general practice is a therapeutic intervention that is taken for granted and performed thousands of times a day nationally, internationally and globally (Duerden 2011). A desire to gain a true insight and further understanding into the lived experience of antibiotic prescribing led me to phenomenology and more precisely Hermeneutic interpretative phenomenology.

My initial thoughts were that I would adopt grounded theory for the study, as it would allow me to build the theory from the data. Grounded theory is recognised as allowing emergent “as is” theory to develop; therefore, the theory is grounded in the data (Glasser and Strauss 1967). However, while discussing a grounded theory approach with my supervisors I realised two important points. Firstly, the methodology may not be the best choice for my study because the timeframe I had to complete my research may not adequately allow a theory to emerge, as is the desired outcome of the grounded theory methodology. Secondly, grounded theory is not a descriptive method and would not support the understanding of the lived experience. I reconsidered my chosen research methodology and explored
alternative approaches that would enable me to interpret and understand the experience of prescribing and chose phenomenology.

Phenomenology is a qualitative research approach which is often described as a naturalistic phenomenological approach (Speigelberg 1960); naturalistic because of the way data are collated and phenomenological in the way such data are analysed. In its simplest terms, phenomenology allows researchers to understand better the lived experience, which we, as human beings often take for granted.

I could have taken a quantitative approach and reported what a given number of general practitioners said or did. Whilst this may have been useful in understanding further prescribing patterns and statistical analysis of prescribing, using this approach would not have given a true, deep and meaningful insight into the lived experience of prescribing from the viewpoint of the medical prescriber. The aim of the study was to understand the GPs’ experiences of antibiotic prescribing. I recognised the overall study aim fitted with the lived experience paradigm of phenomenology but I got lost in the plethora of literature and the challenge to understand fully the writings of the various phenomenologists. However further reading provided me with a greater insight into phenomenology according to both Husserl and Heidegger and I began to appreciate the differences in their approaches, while at the same time recognising the similarities of their philosophical underpinnings (Ricoeur 1981)

3.0 Edmund Husserl and Phenomenology

Many believe that Edmund Husserl is the father of phenomenology (Cohen 1987, Polkinghorne 1983, Scruton 1995, Koch 1996). Husserl became interested in philosophy having first studied mathematics; he believed that by bringing science and philosophy together it would culminate into true phenomenology.
Phenomenology essentially studies the lived experience and is interested in what the experience is like from the experience of the “life world” (Van Manen 1990). The aim, therefore, is to understand what the experience is like for a given individual or a group of individuals (Polkinghorne 1983). Husserl was concerned with human thought, perceptions, and the concept of human beings as knowing the world they encounter, (Wilson and Hutchinson 1991).

The world according to Husserl excludes categorisation but becomes a means for understanding true reality (Husserl 1970). Husserl believed this method provides a way in which true-life meanings can be determined by probing deeper into reality (Koch 1996). To achieve this fully, Husserl called upon his knowledge of mathematical notation and brackets and developed a process of phenomenological bracketing often referred to as reduction. This process involves suspending prior experience of a phenomenon under study in order to see the new phenomenon clearly, bracketing experience off or setting it aside (Osborne 1994). The aim here is to see phenomena as they are, as opposed to what our prior knowledge and experiences perceive such phenomena to be (Sharkey 2001).

As a qualified nurse prescriber, mentored and trained by a General Practitioner, I struggled with the concept that I could truly bracket out my own experiences and understanding of prescribing. I could identify my suppositions of the prescribing phenomenon but I could not set them aside so that they did not cloud or bias my ability to see the phenomenon as it really is. I realised my thinking was at odds with the Husserlian school of thought and I would need to continue my journey to find a methodology that could be applied to my study in such a way that allowed new meaning and greater understanding to emerge. I did not only want to confirm what I thought I already knew. Instead, my aim was to further my understanding of the
research phenomenon in order to understand better the lived experience of medical prescribing and reflect the GPs' experience, without changing the context of the experience in any way (Dreyfus 1991). I then explored the work of Martin Heidegger and applied his concept of Hermeneutic phenomenology to my study.

3.1 Martin Heidegger and Hermeneutic Phenomenology

Hermeneutics essentially refers to the theoretical process of interpretation and as such, the theoretical underpinnings are firmly aligned to interpretative phenomenological analysis. As a methodology, it focuses on the language GPs use to describe their individual experiences, which in turn gives the researcher a true insight and a much deeper understanding of the given experience.

Martin Heidegger was a theologian who later committed himself to Husserlian philosophy. Heidegger was never a student of Edmund Husserl (Sharkey 2001) and later disassociated himself from Husserl and his work. Phenomenology and hermeneutic phenomenology both focus on the human lived experience but Husserl and Heidegger had opposing views of how the lived experience should be explored. Heidegger believed a person’s background and previous experience help to understand phenomena and give them greater meaning. Furthermore, human experience is followed by interpretation, which is influenced by prior knowledge. According to Laverty (2003) Heidegger believed that one cannot eliminate or cast aside previous knowledge and experience, a notion that conflicts the beliefs of Husserl. Cohen (1987) suggested that Heidegger, at odds with the theories of Husserl, focused on the issue of “being” and what it means to be. As such, interpreted Hermeneutic phenomenology in the following three ways:

1) As an attempt to understand each experience as encountered or presented to us
Heidegger is focused on the process in which the very basic core structures of “being” are known and understood and how the associated experiences are then understood (Ricoeur 1981).

2) How we as human beings understand phenomena in the world in which we live
This relates to the ontological investigation of encounters and experiences and how such experiences are interpreted and understood, which focuses on how people interpret their lives and make meaning from their experiences (Ricoeur 1981). In the context of this study, the focus is on how the GPs interpret their lives as medical prescribers and make meaning of those experiences.

3) As an attempt to understand being as an entity (Dasein)
Dasein is a German word, which translates to “being there” (Solomon 1972). Relating to human beings, Heidegger believes the substance of man lies in his very existence, which he refers to as Dasein. Dasein is an ontological entity and Heidegger is trying to reveal the ontological structure of being, which he refers to as existence or presence (Giorgi 2007).

As human beings, we face making choices where the options are not equal or available to all. Our uniqueness as human beings brings with it chances and opportunities that are equally unique to each individual. However, how we use or ignore each opportunity may reflect whether we are likely to reach our potential and this aligns to Dasein and our being in the world (Dreyfus 1991). For Heidegger, Dasein exists in one of two modes, either authenticity or inauthenticity. Both relate to “being in the world” and must be seen as a whole (Dreyfus 1991).
According to Heidegger authentic existence is only achieved when human beings realise who they are and that each individual is a distinctive entity. This recognition of uniqueness becomes an “authentic” concern as human beings aspire to reach and fulfil their potential within the world. When individuals fail to recognise their individuality and uniqueness, they are living an inauthentic existence, becoming one of the crowd, embracing societal beliefs, values, and behaviours. Individuals living an inauthentic existence often fail to spread their wings, broaden their horizons, or reach their full potential (Warnock 1970). The GPs in this study were all medical professionals who had taken the opportunities afforded to them in terms of medical school and beyond. Therefore, in accordance with Heidegger’s theory of Dasein, all the GPs could be classified as living an authentic existence.

Hermeneutic phenomenology, unlike other research paradigms, is not culturally or structurally driven. Instead, the key is in understanding individual human experiences of phenomena and the interpretation of those experiences (Sharkey 2001). Using hermeneutic phenomenology, I could explore the experiences of the GPs with further interpretation based on my own knowledge of the phenomenon. Furthermore, my experiences would support me in truly understanding the experience of GPs.

Hans-Georg Gadamer, a former student of Heidegger, concurs with the theory that Hermeneutic phenomenology is a tool for understanding the world in which we live and how the experiences of that world are interpreted. Essentially, both Heidegger and Gadamer seek to understand how we, as human beings, interpret our lives and make sense of those experiences. Gadamer recognised that life experience and language are inextricably linked, appreciating that mind and body do not function in an independent “silo” manner but are very much interlinked. Much of what we learn from the lived experience we gain through language and the subsequent interpretation of that language, which in turn leads to an understanding of the
experience as if we had “walked in that person’s shoes”. When themes begin to emerge it reinforces our understanding of a phenomenon and allows us to draw conclusions from a given experience (Sharkey 2001).

From reading the literature, my understanding is that every experience is unique to each individual. However, while individuals may report similar points, there will undoubtedly be an element of the experience that is entirely unique and differs completely from others who have been exposed or encountered the same or a similar experience. For example, if I were to ask a group of doctors to share the lived experience of the first day on a medical ward as a qualified doctor, there would undoubtedly be commonalities in their responses. There may also be individual recalling of the experiences that no other doctor mentions but never the less, the richness of that individual experience heightens our understanding of that particular experience. In hermeneutic Interpretative phenomenology, even the smallest amount of data is recognised. If an experience is powerful for one individual, it is important despite that it may not be representative of all. Analysis of such rich naturalistic data involves analysing all data pertaining to each individual. The data are not processed collectively.

In line with Heidegger’s theory, I chose Hermeneutic interpretive phenomenology for this study, as the epistemological position fits with the research question and my study aim of understanding the lived experience of antibiotic prescribing. Using such an approach allowed the GPs to talk freely about their experience of prescribing and their prescribing decisions (Beck 1993). Ajawi and Higgs (2007) suggest that using a Hermeneuteic approach adds an interpretive element to explicate meanings and assumptions that GPs may not articulate. However, I believe this is patronising, given the GPs in this study were all highly intelligent professional experts. Through
interpretation comes new meanings and interpretation then becomes the process by which one can make sense and better understand phenomena (Beck 1993). This fits with the ontological perspective of the interpretivist framework and the link between the researcher and the known. This is consistent with the work of Gadamer (1975), who recognised a link between interpretation and understanding, with interpretation being an on-going iterative process (Polkinghome 1983). Interpretation according to Hermeneutic interpretative phenomenology involves a movement between meaning and understanding an experience “as is”, (Annells 1996).

An awareness of my interpretation and experience of prescribing did not hinder or halt new meanings and understanding from emerging. Rather, it assisted the process. Heidegger referred to this as a process of surrendering and the assimilation of insight (Sharkey 2001). By understanding the research in this way, it allowed me to test my prior understanding of the experience of prescribing. Like Heidegger, Gadamer strongly supported the notion that using one’s previous experience allows for a much broader and deeper understanding of a phenomenon. Gadamer did not support the concept of bracketing, believing it to be impossible. Within hermeneutic interpretive phenomenology, information from the GPs and personal reflections from the researcher can be included within the data (Laverty 2003).

My experiences of prescribing were the starting point for this study and without doubt affected how I viewed the study. I could not eliminate those experiences because as Laverty (2003) recognises, it is not possible to view human life outside of experience. Adopting Hermeneutic phenomenology did not supply me with a rigid set of prescriptive rules but rather a robust framework for interpreting and understanding the lived experience of antibiotic prescribing in the context of medical prescribing. Furthermore, it allowed me the freedom to broaden my interpretative horizons whilst
appreciating that something new, albeit something that did not confirm or support my prior experience, may indeed come out of the research.

3.2 Aim of the Study and Research Question

The aim of this study was to explore the lived experience of antibiotic prescribing and answer the research question: What is the lived experience of antibiotic prescribing in the context of medical prescribing?

3.3 Methods

I used Hermeneutic interpretative phenomenology to explore the lived experience of antibiotic prescribing. I drafted the interview questions in such a way as to optimise the potential for GPs to be completely free to talk at length about their practice of prescribing and the lived experience of antibiotic prescribing. Structuring interviews that are open and focus on free speech from the interviewee and little participation from the interviewer is essential for interpretative phenomenological analysis (Silverman 2005). I purposefully designed my question-set in an unstructured way to probe the depths of medical prescribing and the unique experience of each GP prescriber. The goal was to gain as much information as possible from the GPs. Where answers were a little short I used prompts such as “are you able to tell me a little more about that?” The number and type of prompts varied between GPs and was dependent upon the response. Where responses were somewhat superficial, prompts were used to probe deeper in an attempt to elicit depth and richness to the data (Dreyfus 1991). This approach gave the GPs an indication of the level of detail I was trying to extract (Silverman 2005). The interview process was sequential, with responses moving along a continuum from descriptive to analytical, as shown in figure 1.
Each interview commenced with the question, “how long have you been a practicing GP?” This was asked to gain confidence and trust and to make each GP feel at ease. As I moved along the continuum, the question-set began to explore the influences on prescribing antibiotic therapy (descriptive), as GPs were purely describing what those influences were. The interviews then moved to explore the lived experience of prescribing (analytical). GPs reflected their individual lived experience of medical prescribing. It was important that I allowed time for each GP to respond fully to each question. I did not want to rush or appear hurried, as this may have restricted the quality and depth of the response (Osbourne 1994). At the end of the interview process, several GPs commented that never before had they thought about and reflected on their experience of prescribing. The interview process had prompted these GPs to reflect what the experience actually meant for them. Two of the GPs used the word cathartic to describe the interview process, one GP said it had been enlightening, and another said the interview had been “a truly reflective process which felt good.”

To make it convenient for the GPs and to reduce any potential pre-interview anxiety, I asked each GP if they would like to choose the time and venue for the interview. With the exception of one GP, whose interview I conducted in the surgery before morning consultations commenced, all GPs chose their respective GP surgeries at the end of
afternoon practice. Each interview was scheduled to last at least one hour. Figure 2

demonstrates the location and duration of each interview.

<table>
<thead>
<tr>
<th>Interviewee Number</th>
<th>Location of Interview</th>
<th>Duration of Interview</th>
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<tbody>
<tr>
<td>001</td>
<td>Surgery</td>
<td>70 minutes</td>
</tr>
<tr>
<td>002</td>
<td>Surgery</td>
<td>63 minutes</td>
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<td>003</td>
<td>Surgery</td>
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<td>004</td>
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<td>005</td>
<td>Surgery</td>
<td>60 minutes</td>
</tr>
<tr>
<td>006</td>
<td>Surgery</td>
<td>67 minutes</td>
</tr>
<tr>
<td>007</td>
<td>Surgery</td>
<td>79 minutes</td>
</tr>
<tr>
<td>008</td>
<td>Surgery</td>
<td>58 minutes</td>
</tr>
<tr>
<td>009</td>
<td>Surgery</td>
<td>66 minutes</td>
</tr>
<tr>
<td>010</td>
<td>Surgery</td>
<td>65 minutes</td>
</tr>
</tbody>
</table>

Figure 2

As a lone female researcher among a population of male GPs, I was initially a little
concerned that there may be some gender bias with the GPs more willing to be open
with a researcher of the same sex (Munhall 1989). Much literature exists on the risks
and benefits of same sex and different sex interviewer to interviewees (Munhill 1989,
Polit and Hungler 1999). However, my experience demonstrated that this cause for
concern was unfounded, with GPs responsive and willing to talk in depth about their
experience. I recognise that the sample size for this study was small and that had I
recruited more GPs, the outcome in terms of gender bias may have been different.

While all interpretative phenomenological researchers share the common goal to
understand and interpret the “life world” and lived experience of their research
participants, there is no set way to analyse such data. Within this type of research,
data analysis is not prescriptive or governed by a tight set of rules. However, there
are methods and frameworks to give structure to data analysis. One of the most
commonly used frameworks is the work of Steinar Kvale and the six steps to data
analysis, detailed further in section 3.6.
3.3.1 Sample

The aim of the GP selection was to include GPs that not only had experience of the medical prescribing phenomenon but whose differences would generate rich data from their unique lived experiences (Van Manen 1990). I chose purposive or judgemental sampling for the study with the sub section of expert sampling (Van Manen 1990). This is a type of purposive sampling used when gaining knowledge from individuals with particular expertise. All the GPs were experts on the subject of the experience of antibiotic prescribing, which was the focus of this study. I invited GPs from an area within the south of England in order to represent the unique experience of prescribing in affluent, poverty stricken, and diverse localities (Van Manen 2006).

The sample group was homogenous in terms of their occupation and roles. To avoid a regional bias from any one single context, local policy or expert’s advice, I selected GPs from four zones of an area within the south of England, which included urban, rural, and semi rural practices. Using the four separate regional groups optimised the trustworthiness of the data (Sharkey 2001) and added to the transferability of the findings (Kumar et al. 2003). This method of sampling fits with the overall aim of the study and is therefore appropriate (Polit and Hungler 1999). By using such a sampling strategy, purposeful and relevant information was forth coming, which in turn supported the analysis of quality data (Polit and Hungler 1999). All GPs had both knowledge and experience in the research area and figure 3 demonstrates the number of years the GP has been in practice. To protect the anonymity of the participants, characteristics relating to ethnicity, size and type of practice have purposely not been included. However, the geographical classification of the practice is shown in Figure 3.
Given the number of general practitioners nationally, this study was small as only ten GPs participated. The reasons for this were twofold. Firstly, the time constraints of undertaking a study for an academic qualification put limitations on my study. Secondly, as a lone researcher, recruiting a small number of GPs allowed me to immerse myself in the research, personally interview all the GPs individually, transcribe and manually analyse the data, and write up my findings. Undertaking these activities and moving through the various stages of the research process allowed me to see hermeneutic phenomenology in action and gain a greater understanding of each individual experience, as the GPs had lived it (Smith and Osborn 2007).

### 3.3.2 Inclusion Criteria

The inclusion criteria for the study was broad, with all qualified GPs currently working either full or part time within general practice eligible to participate. There were no restrictions regarding how long a GP had been qualified. Both male and female GPs were eligible for inclusion in the study but for unknown reasons, no females came forward.
3.3.3 Exclusion Criteria
The following exclusions were applied to the study:

- Locum general practitioners
- Trainee general practitioners
- Retired general practitioners

3.3.4 Recruitment
Letters were sent to GPs inviting them to participate in the study (Appendix 1). Respondents were checked against the inclusion/exclusion criteria and ten male general practitioners were recruited. On recruitment each GP received an information sheet giving background to the study and a consent form (Appendix 2 ad 3).

3.4 Ethical Considerations
Through the interview process, the GPs underwent a process of reflection, self-appraisal, openness and transparency; therefore, it was paramount that the overall wellbeing of each GP was considered (Beauchamp and Childress 2001).

I considered the ethical principles as follows:

The University of Surrey Ethics Committee and my local Ethics Board granted ethical approval for this study. Each GP received an information sheet (Appendix 2). All information pertaining to the GPs was anonymous and held on a password-protected database; thus respecting and maintaining the welfare and dignity of the GPs throughout the study. As the researcher, I am aware of the identity of each GP but I am bound by the duty of confidentiality in accordance with the Nursing and Midwifery Council (NMC) Code of Conduct and the principles of the Caldecott Guardian. Once I transcribed the data, a coded number referred to the GPs and I coded the tape recording and subsequent transcript in alignment with each GP.
I informed each GP before the interview that they could stop and terminate the interview at any point. Each GP was informed that they did not have to answer a question if they felt uncomfortable in doing so.

When undertaking a study such as this, the researcher must undertake a risk benefit analysis to determine potential harms that may befall participants and then weigh this against the benefits. With this in mind, I considered the principles of non-maleficence, as I intended no harm to befall the GPs (Polit and Hungler 1999). No physical or psychological harm came to any of the GPs in this study during or after the interview process. In terms of beneficence or benefits, general practitioners had the opportunity to gain an enhanced awareness of the lived experience of prescribing and how this influences or changes their prescribing decisions and practice.

To ensure respect for each individual GP, I obtained informed consent before each face-to-face interview (Appendix 3). Participation in the study was purely voluntary and none of the GPs received any payment or incentive to participate in the study. To ensure the study was fair and just, each GP was treated the same and was party to the same pre study information.

3.5 Data Collection

3.5.1 Face-to-Face Interviews

As a lone nurse researcher, I had to demonstrate to the GPs that I was a confident and competent interviewer. Therefore, I had to ensure the interview process was well planned and robust. To provide structure I used the seven stages of an interview investigation as proposed by Kvale (1995):

1. **Thematizing**: The purpose of the investigation was formulated and the concept of the topic being investigated explained to each GP via an information sheet before the
2. **Designing:** I planned the study, drafted a study proposal, and considered the ethical dimensions before the commencement of the interview process.

3. **Interviewing:** I conducted the interview in accordance to an interview guide and with a reflective approach to the knowledge sought (Appendix 4).

4. **Transcribing:** I transcribed the recorded interviews from oral speech to written text.

5. **Analysing:** I reviewed data analysis tools, frameworks and computer programmes, and decided to manually analyse the data based on the principles of Kvale’s six stages of analysis (detailed further in chapter 3, section 3.6).

6. **Verifying:** I fulfilled the study aims by investigating, analysing, and reporting on my chosen topic.

7. **Reporting:** The study was conducted with the final report in mind and the report was then written to reflect the lived experience of the GPs. The methodology was made clear and ethical considerations were detailed.

Face-to-face unstructured interviews were conducted between October 2010 and January 2011, open-ended questions asked and each GP invited to share their experience of prescribing. The open nature of the interview allowed GPs to think, reflect, and articulate what the lived experience had been for them as individuals (Geertz 1973).
3.5.2 Use of tape recorders in face-to-face interviews

There has been much debate within the literature regarding the use of tape and video recordings when interviewing and the impact, both positive and negative, on the richness of the data. Koch (1996) suggests that such objects may act as a barrier for participants. Perhaps it is because participants may not be completely open or hold back information for fear that the recording is a form of “evidence”. I used a tape recorder because I wanted to use verbatim quotations from the interview, interpret, and understand what the GPs had really said.

The process I used for data storage and protection complied with the principles of the Data Protection Act 1998. I ensured that each GP understood the following:

- The tapes and data transcripts would be anonymous
- The data would be used for the purpose of this study only
- The tapes would be stored securely in a locked cabinet in my office
- Each tape would be kept for ten years
- No information, or data would be passed on to a third party

Each GP had the opportunity to listen to the recording and read the transcript and I gave verbal assurance that I would delete any response that a GP did not want included. None of the GPs requested that content be deleted. I did not take excessive notes during the interviews as this may have caused the interview to become fragmented, with GPs not freely speaking but stopping to give me chance to write. This could have caused a stilted interview and resulted in somewhat scripted responses, rather than the free speech that needed to obtain natural rich data that reflected the GPs' lived experience (Smith and Osborn 2007).
I made notes of non-verbal signs made by each GP, particularly when there were silences because these non-verbal signs were equally as valuable and provided a “between the lines” insight into what was really said, which is a reflective consciousness of the lived experience (Kvale 1995). The non-verbal signs provided me with an indication of the thoughts and feelings of the GPs as the following example demonstrates.

When asked by the researcher:

“Do you think you should consider the risk of Clostridium difficile”?10

The GP looked away, became very interested in the empty coffee cup, sighed, coughed, and then replied:

“Um, no, no not at all, Carol. I’m somewhat wary of this question, that’s twice you’ve mentioned C.difficile”.

The non-verbal signs demonstrated that this GP was uncomfortable with this question and while he could have refused to answer, he went on to give a response that confirmed what had been communicated through non-verbal actions. The GP was told that he did not have to answer the question and when a response was forthcoming, the GP was further informed that the question and response could be deleted from the tape. However, the GP’s response was as follows: “No, don’t do that” followed by “I think we’re done here”.

10 The GPs were asked about Clostridium difficile as a way of introducing antibiotic prescribing and because little is known about GPs knowledge base of Clostridium difficile in relation to antibiotic prescribing. By asking the question I was able to better understand if the GPs in this study recognised a correlation between their antibiotic prescribing and Clostridium difficile and if so did it influence their prescribing particularly in high risk patients such as the elderly and patients with serious underlying disease.
Reflecting on the GP interviews, I realised that whilst I had read much on hermeneutic phenomenology, it was not until I was embroiled in the interview process that I really began to understand what hermeneutics actually is, what it means, and how unique each experience is.

3.6 Data Analysis

The aim with any data analysis is to understand the content and complexity contained within the data. Qualitative data analysis is a personal process and relates to the process of interpretation, undertaken by the researcher at each analytical stage (Smith and Osborn 2007). Hermeneutic interpretative phenomenology analysis typically commences as soon as data collation begins, because there is a natural tendency for the researcher to read the transcripts and begin interpreting them in order to gain insight and understanding (Cohen 1987). For me, the analysis process began during the interview while I was listening to each GP and interpreting, albeit rather crudely, what the GPs had actually said. As soon as I transcribed my first set of data, I enthusiastically began making notes and highlighting words, comments, and phrases in order to elicit meanings and gain an early understanding.

There is no defined way of analysing hermeneutic phenomenological research (section 3.4), because the approaches are diverse and many options are available (Van Kaam 1966). Unlike the phenomenological approaches set out by Colaizzi (1978), who suggests returning transcripts to the participant with statements extracted by the researcher before formulating cluster themes, hermeneutic interpretative phenomenology adopts a different style to data analysis and typically uses the hermeneutic circle and attention to language and writings (Koch 1996).

The hermeneutic circle is the ontological basis of how we understand each other in
relation to our lives and experiences (Dreyfus 1991). This concept fits with the study aim of understanding the GPs experience as if it were my own. Heidegger proposes that the hermeneutic circle enables a deeper understanding of existing knowledge. It is not a tool to seek out new knowledge (Ricoeur 1981) but a dialectic process by which interpretation of the whole is understood by interpretation and understanding all of the parts that make up the whole. According to the Hermeneutic circle, no single part of a phenomenon can be understood until the whole is understood Ricoeur (1981). One may conclude from this that true interpretation and understanding can never be reached as this process reflects the "chicken and egg" dilemma. However, this process is merely a way of conveying how interpretation and understanding are an ongoing process, which happens over time (Koch 1996).

To further put this in context, one achieves understanding by interpreting within a circular process. Within the circle, we move from the whole to the individual parts and from the individual parts to the whole (Debesay et al. 2008). In order to understand each lived experience as a whole, I needed to understand all of the individual elements or the parts as determined by the whole, while the whole was determined by the individual elements of the work. In order to know what the experience meant as a whole, I needed to interpret and understand what each individual piece of data meant. However, I could not be sure what the individual data meant until I understood the meaning of all the data regarding the whole experience. This is because each GP statement needed a context in order to mean something. Taken in isolation, data relating to GP statements appeared to be random. Statements became meaningful when put together to reflect the whole and the whole became more meaningful when I understood each of the individual data sets or parts. Only then could I truly understand the lived experience of prescribing as told by each GP. For example, had I solely focused on one part of the lived experience such as time, I
would have gained an understanding of the effects of time on prescribing. However, I
would not have seen or understood the other parts that made up the whole
experience, such as patient expectations and professional reputation. Therefore, by
looking at the whole, I could contextualise time as a part of the whole lived
experience. Honing in between the single parts of the prescribing experience and the
whole experience many times helped me to interpret and understand the context of
the parts in relation to the whole experience of medical prescribing. Figure 4
demonstrates how understanding was achieved using the Hermeneutic circle and
shows some of the parts that made up the whole prescribing experience (figure 4).

The Hermeneutic Circle in Action

The circle below shows some of the parts that made up the whole lived experience of
prescribing. Interpreting and understanding each part led to an understanding of the whole.
However, to understand the whole, each individual part had to be understood.

Figure 4

I adopted an eclectic approach to my data analysis because I wanted to be certain
that I had not overlooked or omitted any data that could add depth or further
understanding of the lived experience of antibiotic prescribing. I loosely based my
analysis on Kvale’s six steps of data analysis, explained below.

1) Participants describe their lived experience during the interview

The GPs described their unique experience of prescribing during the face-to-face
interview process.

2) *Participants themselves discover new relationships during the interview for themselves*

The GPs discovered, through the interview process, new meaning in what they see and do with regard to prescribing.

3) *The interviewer, during the interview, condenses and interprets the meaning of what the interviewee describes*

During the interview, I began to interpret the meaning of what the interviewees described. I reflected the meaning back to the GPs to ensure I had interpreted and understood correctly.

4) *The transcribed interview is interpreted by the interviewer*

I transcribed the interview and began the process of interpretation. The data was first structured and digressions and repetitions eliminated, which helped distinguish between the essential and the non-essential. The analysis involved developing the meanings of the interviews and bringing the GPs’ own understanding into the light as well as providing my own new perspectives of the phenomenon.

5) *The participants get the opportunity to comment on the interviewer’s interpretations*

After the interview the GPs had the opportunity to comment on my interpretations of their individual interview as well as elaborate on their original statements.

6) *Participants begin to act from new insights they have gained during the interview*

I have not yet had the opportunity to follow up with the GPs to see if they have made
any changes in practice following the insights gained from the interview process. However, one of the GPs told me briefly in passing that he is now involving patients more in treatment decisions and subsequent care pathways.

I analysed the data manually and while time consuming, it allowed me to really scrutinise the data in a way that I may not have done had I been reliant on an analysis programme. Manual analysis allowed me to appreciate both the commonalities within each GP's data and the stand-alone comments that made each experience unique. The more I read the transcripts the more data I found and the analysis became an iterative process with each reading and rereading of the transcripts. Van Manen (1990) refers to this process as immersing oneself in the data. From the process of immersion comes interpretation; albeit in a raw or initial state and this became the driver for the next stage of analysis (Sharkey 2001). The next stage of data reduction involved decisions relating to the relevance of data and what would be included in the writing up of the findings. It was particularly important for me to ensure that during this process of reduction I did not edit the data as this may have resulted in discarding an important or unique point that may have added to the body of knowledge (Cohen 1987). The following extract is an example of data reduction:

Data: “Um, ok, (Long Pause) Let me think. Well I guess patients can be demanding not necessarily in a negative way”

Data reduction: Patients can be demanding, not necessarily in a negative way

Cohen (1987) suggests that removing digressions in this way does not change the context of the data or have a negative impact on the final analysis.
The next stage of the analysis was thematic analysis, which involved a line-by-line coding of the data. While time consuming, it is an extremely important step in the analysis process because it ensured the meaning of the whole lived experience was captured (Yardley 1997:68-91 citing Smith & Flowers 1997). Undertaking this process also reduced the chance of being too reductionist and changing the context of the text data. During this process, I underlined phrases such as:

1) “Having the know how to make patients better, to cure or alleviate symptoms, is powerful, though I’ve never thought of myself as powerful before now” and,

2) “Medical knowledge and prescribing together are powerful tools. I have in my head, the knowledge”

I wrote codes in the margins, which is in line with Utrech and his philosophy of data analysis (Yardley 1997:68-91 citing Smith & Flowers 1997). Essential themes such as those demonstrated above in excerpts one and two, were classified as coded exemplars (Cohen 1987). I also used the field-notes I had taken (relating to the non-verbal communications) to support contextualising the data through the writing and rewriting stage (Sharkey 2001).

I had not appreciated the time needed to undertake the analysis, which involved writing and rewriting (Van Manen 2002). This process allowed me to move from identifying and comparing themes to grouping the whole picture in a way that I could understand. Moving through the hermeneutic circle, I was able to progress from identifying themes and commonalities to seeing the “bigger picture” of the whole. Again, this occurred through the process of writing and rewriting and became a robust way in gaining greater meaning of the phenomenon (Sharkey 2001).
The most important element of the analysis was to ensure I was reflecting and reporting truthfully the lived experience of the GPs and not influencing or biasing the results either by including excerpts from those who had the most to say or by including elements that were important to me. My focus was to report the experiences as told by the GPs and not change the context of those dialogues, which is the ultimate goal in hermeneutic phenomenology (Yardley 1997:68-91 citing Smith & Flowers 1997). An example of the early stage of the data analysis is shown in figure 5.

<table>
<thead>
<tr>
<th>Data</th>
<th>Code</th>
<th>Theme</th>
<th>Sub Theme</th>
<th>Hermeneutic Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>I make the decision whether or not to prescribe</td>
<td>04</td>
<td>2</td>
<td>1</td>
<td>Part 4</td>
</tr>
<tr>
<td>Patients form opinions of you</td>
<td>03</td>
<td>4</td>
<td>1</td>
<td>Part 3</td>
</tr>
</tbody>
</table>

Figure 5

On reflection, I based my beliefs about the phenomenon on my own experience of prescribing. My focus, therefore, had to be on the text data from the GPs. I challenged my understanding of the data by reading and rereading, writing, rewriting, and checking back with the GPs. This process is referred to as member checking (Lincoln and Guba 1985). This self-awareness acted as a tool in reducing researcher bias and helped ensure I listened, heard, and reported the voice of the GPs in a truthful way (Sharkey 2001). The GPs were the experts of their own experience. Interestingly this verification process and the subsequent GP responses in some cases not only provided clarity but also added to the data.

I presented my initial findings to a small group of work colleagues to see if my accounts taken from the texts were clear or if there were areas that needed further clarity. Several questions raised by my colleagues related to the theme of power. I went back to the data to see how I could add further clarity and reflect a true interpretation of the analysis that would be clearly understood.
3.7 Managing the Data

It was necessary to have an organised system and process for managing the data and I followed the five steps of data management as proposed by Hopkins Bloomberg (2008) as demonstrated in figure 6.

<table>
<thead>
<tr>
<th>Five steps for Data Management</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Choose and follow a clear file naming system</td>
<td>The file name was printed on all documents and contained the GP ID number; the type of data collection method, my name as the interviewer and the date the data was collected.</td>
</tr>
<tr>
<td>2. Develop a data tracking system</td>
<td>Consent form, interview tapes, and transcripts were assigned a code and the GP ID number. Data was securely stored and transcripts were backed up.</td>
</tr>
<tr>
<td>3. Establish and document transcription/translation procedures</td>
<td>All interviews were manually transcribed verbatim and included elisions, mispronunciations, slang, grammatical errors, nonverbal sounds, and background noises.</td>
</tr>
<tr>
<td>4. Establish quality control procedures</td>
<td>The transcripts were checked and rechecked against the tapes for accuracy.</td>
</tr>
<tr>
<td>5. Establish a Realistic Timeline</td>
<td>A timeframe was built into the thesis planner for data collection and data analysis. Clear milestones were set and agreed with my University supervisors.</td>
</tr>
</tbody>
</table>

Figure 6

3.8 Rigour, Validity and Credibility

The literature highlights arguments in both the use of terminology and the methodology for reducing researcher bias. The terms rigour, validity, and credibility are often used interchangeably (Cresswell 1998). The validity of this study will undoubtedly rest on the authenticity and believability of the findings as a true representation of the lived experience of antibiotic prescribing (Sharkey 2001, Smith and Osborn 2007). I used Yardley’s (1997) three flexible principles as a “checkpoint” for assessing the validity of this study.

1. Sensitivity to Context:
This chapter demonstrates my understanding of the context of the methodology and associated philosophy, including my awareness of the literature and existing theories. I present the GPs experiences as is without changing the context, which demonstrates my sensitivity to the data. I also gained an appreciation of how the language and work culture/ethic of the GPs reflected in the findings of this study. I recognise how my own approach and subsequent actions may have affected the data (Yardley 1997).

2. Commitment, Rigour, Transparency and Coherence:

This methodology chapter read in conjunction with the rest of the thesis report demonstrates my rigorous application of theory, methods, and reflexivity. Rigour in this context relates to the triangulation of the data, the data analysis, and my subsequent interpretations.

By committing myself to this study, I was able to develop research skills and competencies, which increased my confidence to make decisions regarding data collection, data analysis, and finally reporting of the findings. I have reported the findings from the viewpoint of the GPs, which meets the principle of coherence. With regard to reflexivity, I have detailed how my own prescribing experiences and assumptions affected the research and the final thesis report has been drafted as is, within the context of openness and transparency. I have presented the findings in a way that I hope the reader will find clear and coherent (Smith and Osborn 2007).

3. Impact and Importance:

The impact and importance of this study is that it adds to the body of knowledge and supports theoretical understanding of a practical intervention. The importance will be in sharing the methodologies and the findings, as together they will support others to
develop knowledge and understanding of the lived experience of antibiotic prescribing, (Rappaport 2000).

**Summary**

I have presented the concept of Hermeneutic phenomenology and the research aim and question. The research methods and ethical considerations were detailed before discussing the method of data collection and analysis. I presented how the Hermeneutic circle supports interpretation and understanding of the data and outlined the methods of data management. Finally Yardley’s flexible principles were applied as a checkpoint to assess the validity of this study.
Chapter 4
Findings

Introduction

In this chapter, I use data extracts to illustrate the four key themes with their sub-themes and present the findings of the study. The four key themes are:

1) Getting the clinical decision right
2) Doing the right thing for patients
3) Managing expectations
4) Managing reputation

The themes and sub-themes are outlined in this chapter at section 4.1.

4.0 Themes from the interview data

The GPs shared their lived experiences of prescribing antibiotics. All these GPs believed that advances in medicine such as prescribing of antibiotics have significantly improved outcomes for their patients over the last twenty to thirty years. All these GPs felt they are often subject to criticism regarding poor antibiotic prescribing practice.

One significant finding was that GPs in this study reported that healthcare associated infections did not pose a significant problem in the community. This finding is in contrast to national evidence, which indicates that community-acquired infections such as those caused by Clostridium difficile (C.diff), Meticillin (Methicillin) Resistant Staphylococcus Aureus (MRSA) and pneumonia are steadily rising year on year (Department of Health 2010). While all of the GPs recognised that over use of antibiotics would lead to the development of antimicrobial resistance, all but one suggested it was unlikely that their own antibiotic prescribing would affect this greatly (section 4.1). All these GPs stated their concern for their patients outweighed
concerns of antibiotic resistance and all felt more comfortable prescribing than failing to treat a patient (section 4.2). The GPs in this study shared their experiences of trying to manage patient expectations while feeling pressured into prescribing an antibiotic for a self-limiting illness such as a sore throat or a possible viral respiratory tract infection (section 4.3). Similarly, there was a consensus that most patients never forget the GP who fails to treat them. All GPs felt they had to protect their professional reputation (section 4.4). Interestingly, the financial cost of medicines was only voiced by two of the GPs and for that reason, it is not listed as a theme but is discussed within section 4.2.

Although Heiddegerian hermeneutics does not suggest returning transcripts to the participants, as a novice researcher I felt the need to obtain the views of the GPs in order to achieve greater credibility of the findings. Therefore, I validated the findings with the GPs, who each received a copy of their transcribed recording together with my interpretation. I invited them to comment on my interpretation. Their interpretation differed from mine on one theme sub heading, Feeling Powerful. After seeking further clarity from the GPs I realised the word powerful caused them concern. On reading the content of this sub-theme, all these GPs agreed a faithful interpretation had been made (section 4.2).
### Themes and Sub- Themes from the Interview Data

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting the Clinical Decision Right</td>
<td>• Making clinical decisions&lt;br&gt;• Involving patients in clinical decisions&lt;br&gt;• Managing risks and benefits of prescribing</td>
</tr>
<tr>
<td>Doing the right thing for patients</td>
<td>• Feeling Powerful&lt;br&gt;• Using my clinical Knowledge&lt;br&gt;• To prescribe or not to prescribe&lt;br&gt;• The experience of diagnostic uncertainty</td>
</tr>
<tr>
<td>Managing Expectations</td>
<td>• Managing patient relationships and expectations&lt;br&gt;• Managing family relationships and expectations&lt;br&gt;• Managing the Pharmaceutical industry</td>
</tr>
<tr>
<td>Managing Reputation</td>
<td>• My professional reputation&lt;br&gt;• Managing the reputation of the Practice</td>
</tr>
</tbody>
</table>

#### 4.1 Theme 1 - Getting the Clinical Decision Right

I present how GPs make their clinical decision to prescribe and how they involve their patients in the clinical decision process. I also present the considered risks and benefits of therapeutic interventions.

#### 4.1.1 Making Clinical Decisions

All of the GPs in this study described how, from the moment a patient starts to describe their symptoms, the process of decision-making begins. This may be a subconscious process, which is a form of conditioning because when the GPs hear and recognise the clinical symptoms (stimuli), they act as a catalyst to trigger the decision making process. The findings suggest such a response links to both professional clinical experience and intuition. The GPs described how the decision making process was linked to cues from the patients.

The statement below is a typical response that demonstrates how GPs are conditioned to respond to the stimuli or cues from the patient. Intuition also appears
to be used during the clinical decision making process, which suggests that the decision making process is based on different senses and not just the medical model.

“I tend to get a gut feeling as soon as the patient starts to give me cues, that kind of intuition, I find is never normally wrong, at least it hasn’t let me down yet” (James).

James was asked to clarify further, what was meant by gut feelings and he explained:

“It’s a hunch. You somehow know what to do without really thinking about it, it’s just there, a natural routine” (James).

This suggests that an unconscious automatic process is triggered, which supports the notion of the stimuli activating the decision making response. It does not appear to involve looking at a medical framework of possible information options but rather, looking at options based on intuitive problem solving of the clinical symptoms and a possible force of habit by the GP.

The following extract not only demonstrates intuitive problem solving but also typically represents concerns regarding constraints of time:

“I have ten minutes for the consultation; there isn’t the time to delve into the minutiae. If I think, I’m not too sure but if I don’t prescribe this woman may be off work and I happen to know she’s a single mother. I’ll prescribe, because after all she needs the help” (Paul).

Paul feels empathetic to the patient and when restricted by time he believes prescribing to be in the best interest of all.

All the GPs in this study felt that having a set consultation time of ten minutes was restrictive, with such time pressures resulting in a prescription as opposed to alternative treatment or intervention options. This coupled with other pressures, such as long patient lists, were often another trigger to prescribe. These GPs felt that time pressures not only affected prescribing decisions but also influenced the quality of
such prescribing. The following is a typical response to highlight the aforementioned points:

“Oh of course, I focus on the patient symptoms, what I’m being told and what I can observe for myself but undoubtedly, time is a factor for me. It is quite difficult in the ten minutes I have to listen to the patient, take a history, examine, and then make a clinical decision. I’m also aware that there are other patients waiting to see me. Sounds fairly clear and straightforward sitting here talking to you. The reality isn’t quite so easy” (Geoff).

In a further discussion, I asked Geoff what he meant by easy. He said he felt it was difficult sometimes to balance all the factors involved in a ten-minute consultation. Geoff suggested having to practice this way often made him feel rushed and stressed. The following is another typical example of how, when feeling pressured by time, GPs feels pushed to act and so they write a prescription:

“As a GP, when a patient comes to me I feel obliged to do something and I’ve only got ten minutes to do it. With more and more patients to see, the easiest thing is to write a prescription. I don’t want to prescribe when it’s inappropriate” (Steve).

Steve feels obliged to do something but saying no does not appear to be an option. Instead, he chooses the quicker option of prescribing. Steve refers to prescribing as an easy option as it allows him to fulfil his perceived obligation to do something in a timely way. Prescribing may make him feel more comfortable. The use of the word inappropriate is interesting and suggests practicing in a less than acceptable way. Post interview, I asked Steve what he meant by inappropriate and he confirmed my interpretation, stating that he had meant doing something that was not clinically indicated. Time factors are a concern for all GPs and when restricted by time, GPs try to find a solution that is acceptable to all, as demonstrated in the following example. However, the clinical decision taken in this instance may not necessarily be in the interest of best practice:

“You want patients to feel better, by prescribing an antibiotic they’re happy, you’re happy that you’re not too far behind with your list. Win, win, no harm done and nothing wrong with erring on the side of caution” (Kevin).
Using the word happy suggests that taking a cautious approach makes Kevin feel less stressed. Kevin was asked later how the process had made him feel. He said he felt happy to have reached an outcome that was acceptable to himself and the patient.

The GPs in this study agreed that the decision to prescribe is multi faceted and the following typical response demonstrates this:

"Persuading some patients that they don't need an antibiotic can take longer than ten minutes. I find myself justifying my clinical decisions and negotiating with patients and that in itself is time consuming" (John).

As well as clinical signs and symptoms, other key influences for John are not only time but also patient expectation. John feels he has to use his negotiating skills as a means of justification and yet persuasion and negotiating take skill and time (discussed further in section 4.3). By using words such as I find myself, John implies that initially justifying the clinical decision happens subconsciously but once he becomes aware he feels irritated with himself. Having to justify decisions is not something that all GPs felt comfortable with. Many were not used to questions or challenges about the decisions they make.

GPs suggested that often, there is no clear clinical rationale for prescribing other than time restraints and the need to get through the patient list. The following is a good example of this:

“I’ll hold my hands up, I’ve prescribed an antibiotic before just to get someone out the door, prescribing based on what, I’m not sure, predominantly the need to get on. I don’t want to prescribe inappropriately but I know at times I have” (George).

The first few words of the extract are almost defensive but honest and demonstrate that George knows that the decision is not clinically focused. It seems that George is basing his decision on the perceived wants of the patient, coupled with the pressure
of knowing other patients are waiting. When the tape recorder was turned off, George was asked what he meant by inappropriate. His response was as follows:

“Giving a prescription without really determining if the patient truly needed it. I don’t feel good in these situations because I feel as if I’ve cheated the patient even though they’ve got what they wanted. Yes, it doesn’t really make me feel good” (George).

This demonstrates that George knows what should happen during a consultation but feels under pressure to get through a busy surgery. He makes a decision to prescribe based on non-medical factors such as time. Cheating the patient implies a kind of deceit and therefore needed further clarification. When asked if this was what he meant, George said he felt he had misled the patient into believing they needed the prescription when they may not have. Suggesting the patient got what they wanted implies that George has met patient expectations (I explore patient expectations in section 4.3). This so-called cheating of the patient made George feel guilty because the patient had not received a decision based on clinical symptoms, a fact he reaffirms at the end of the response.

To improve the quality of GP decision-making, many computerised programmes exist to support clinical decision-making. The idea is to ensure the quality of decisions is consistent but not all GPs welcome such support systems. The statement below is an example of the frustration some GPs feel in dealing with perceived risks to autonomy and increased accountability:

“Now we can’t even make our own decisions. They give us a support system but I didn’t make that decision, the computer did. Whose neck is on the block if it all goes wrong? Not that computer that’s for sure. No, I’m the scapegoat. Why would they take that away from us? It’s an automatic process for me as a GP and for all doctors come to that” (Kevin).

The statement implies that Kevin believes he is accountable for the decision made by the software system rather than recognising the system as a tool to support clinical decision making. Asking “why they would take that away from us” suggests a feeling
of losing control and a misconception that he can no longer make his own clinical
decisions. Kevin feels he will be held accountable for all decisions including those not
made by him, hence he feels he is a victim (scapegoat). I asked Kevin what he
meant by an automatic process:

“An automatic process, a natural process, making a clinical decision is
inevitable. I will start to piece things together from my examination of the
patient and what the patient tells me” (Kevin).

This comment links with the aforementioned clinical decision making response to the
stimuli of the patient symptoms.

The findings suggest that clinical decisions are often habitual and contextual and not
based on any clinical rationale. It appears that the habitual practice of GPs might
have overlooked the aspect of patient choice and suitability of medications. Support
systems are not designed to incorporate all patient circumstances. The ultimate
responsibility for all clinical decisions lies with the individual GP. Most of the GPs
failed to recognise that the systems were there as a tool to support them. Instead,
they focused on their personal accountability should things go wrong. As with most
electronic systems, they are only as good as the data entered but the GPs did not
acknowledge this.

There were several risks and benefits considered when making prescribing choices
relating to antibiotic therapy. The GPs considered efficacy and all but one considered
mechanisms of actions and side effects. (I explore risks and benefits of prescribing
further in section 4.1.3).

All GPs agreed that other practice partners were a means of support, particularly
when prescribing new drugs. The following extract is representative of how the
experiences of fellow GP partners support prescribing decisions:
“General practice is isolating as it is. It would be hard as a clinician if I didn’t have practice colleagues to bounce things off. If I haven’t used a drug before but I know a colleague has, I’ll talk to them about it, get an opinion and advice” (Josh).

The feeling of isolation is interesting as although Josh works in a partnership organisation, he describes the accountability for general practice decisions sitting firmly with individual practitioners. Feelings of isolation may also extend to those working in single-handed practices, where essentially there are no other practice partners for GPs to discuss their clinical opinion. With the tape recorder off, I asked Josh what he meant by the word hard; he said he meant tough. Josh felt his colleagues were a good resource and a means of support and to not have that would cause Josh to feel isolated and stressed because there would be no practice support.

Having partners within the practice made Josh feel reassured and helped alleviate some of the anxiety he felt in relation to pressures in general practice. Similarly, the following is an example of how partnership working and utilising the skills of colleagues makes GPs feel supported and reassured. The following extract also suggests a feeling of belonging:

“I can never understand why any GP works as a single hander practice. I mean you are completely on your own. I would find the isolation stressful. When there are partners in the practice, we meet, discuss cases and it’s good to know that your thinking is in line with your colleagues. Likewise, if you’re stuck or not sure on a course of action, talking it through with colleagues you know well and trust is helpful. Having someone reaffirm your thoughts takes away the anxiety of uncertainty, it makes you more confident with the decisions you make” (Peter).

Peter implies how in times of uncertainty he feels more confident when practice colleagues corroborate his thoughts or actions taken. Again, like Josh, Peter also acknowledges that working as a lone GP in a practice causes feelings of isolation and stress as there are no other colleagues to discuss patients and subsequent treatment options.
4.1.2 Involving Patients in Clinical Decisions

All GPs recognised that the concept of shared decision making and forming a partnership between doctor and patient is not new. GPs were aware that over the last ten years, many stakeholders including the Department of Health (DH), the media, and patient and public forums, have all focused on putting the patient at the heart of all clinical decision making. Despite this, in practice the level to which these GPs involve their patients in the decision making process varies. The following extract is a good example to demonstrate that while GPs may understand the concept of shared decision making it may not be standard practice:

“No, patients come to me with a problem; in return I instigate investigations or courses of treatment. That is the partnership agreement between a doctor and the patient. If patients knew how to treat themselves they wouldn't be banging on my door now would they?” (Michael).

The perceived unwritten partnership agreement is interesting because the doctor has a duty of care to the patient but no formal or informal partnership agreement is in existence. Michael believes that the patient is somehow not only aware but in full agreement with this partnership arrangement and is seeking an opinion in a rather prescriptive or didactic way. It demonstrates that patients are not involved at any stage of the decision making process, which suggests there is no partnership at all. Similarly, when I asked GPs if they would explore a range of treatment options with the patients, some suggested this was not a considered option. The following is a good example of this:

“No, I have ten minutes per consultation, there’s isn’t time for all that. Besides, the patient wouldn’t necessarily know what I was talking about and then they would only ask me what I thought was best. No, that’s ridiculous. My patients can rely on me to give them answers, when I am unable to do that, I either order further investigations, or refer on” (John).

Again, the doctor patient relationship is not equal and John was dismissive of patient knowledge and understanding. John appears to base the consultation on what is important to him, such as his own knowledge and meeting his time constraints.
Suggesting patient involvement to be ridiculous may relate to John’s own feelings of fear or possibly lack of knowledge on his part. The perception that patients would not necessarily know what John was talking about is an honest statement because not all patients would have such an understanding. However, such a hierarchical top down approach excludes patients in decisions. John believes he is acting in the best interest of his patients but has overlooked the fact that given a choice the patient may in fact wish to delegate responsibility for their care and treatment to John anyway. John seems to feel threatened by possible challenges to his authority and knowledge, so by not involving the patient, John believes he has mitigated the risk of challenges to his authority.

In contrast, some GPs shared their experience of how, in a medical emergency, a top down approach is necessary. The following is a good example of how, in such an instance, the GP becomes the key decision maker. The GP acts in the best interest of the patient when the patient is unable to make or participate in decision making;

“I try to draw the patient into the conversation when making decisions about them but it’s not always practical. I prescribed an antidepressant injection for a patient once after discussing all the options with the patient. The practice nurse gave the injections and then the patient collapsed and was clearly anaphylactic. Obviously, I got adrenaline and what have you and called the ambulance. The patient survived and all was well. I wasn’t going to ask the patient what she wanted to do. In that situation, I had to act and act fast. It’s a question of common sense” (Josh).

The extract demonstrates that in a non emergency situation, the patient may be involved in decision making. However, when an emergency occurs Josh, with his expert knowledge, acts to resolve a potentially life threatening situation.

Some GPs shared their experience of how they perceived the two-way partnership between themselves and the patient. GPs empower patients by giving them the information to make a more informed decision. The following extract is a typical
example of this because it follows more of an informative model. Peter still holds the power by determining what and how much information to share with the patient:

“Yes, I try to involve the patient for several reasons. Firstly, my belief is that a well informed patient is more likely to be compliant with any treatment plans and secondly, patients tend not to keep coming back if you tell them what to expect and what may happen as a result of a prescribed treatment” (Peter).

In this case, Peter recognises the many advantages to patient participation in the clinical decision making process, particularly in relation to advocated treatments. Yet the use of the word compliance is paternalistic. It seems Peter believes well informed patients are more likely to do as they are told, with no mutual agreement reached. Essentially, his intentions are well meaning because Peter is trying to impose a ‘shared’ understanding of the issue and the subsequent management with the patient. In the long term, his approach may save time, as the patient does not keep coming back to the GP. The word concordant may have indicated that Peter believed in patient participation.

The following extract is a good example of how patient involvement can lead to improved patient outcomes in terms of managing health concerns and treatments:

“It was my last patient of the day. The patient was relatively young and experiencing severe menopause symptoms that were affecting her badly particularly at night. She told me she couldn’t sleep, was exhausted, and I could see she was close to tears. My wife had had a terrible time with similar symptoms, so I really wanted to help her. She was adamant she did not want HRT (hormone replacement therapy) I wasn’t sure what else I could offer so I turned my computer screen round and together we looked at different options that may help. We agreed on a course of action and I told her to make a follow up appointment but to call me if things did not improve. When she came back she was a lot happier, still with some symptoms but not as severe. It was a good outcome. I’m not sure I could have done that in the middle of a busy surgery” (Michael).

Whether applying such a model to practice would consistently achieve such positive outcomes is unclear. In this instance, Michael is working in partnership with the patient to choose appropriate treatments, which are key elements for enhancing patient safety, patient adherence, and therapeutic efficacy. The extract highlights how Michael’s personal experience leads to feelings of patient empathy and a
greater understanding of the problem. He understands the complexities of the menopause through observing similar symptoms in his wife. He feels a need to help this patient and in doing so, draws her in to look at options and treatments. The extract demonstrates that when time permits, partnerships working between the GP and the patient results in a positive experience of care for the patient. It also demonstrates reflexivity and learning through personal experience.

Many of the GPs spoke of how they had the best of intentions for partnerships working with patients. However, some GPs found that not all patients wish to be involved in this process. The following extract is a good example of this:

“It’s difficult sometimes to involve patients in the decision making process. Some patients don’t want that, they look to you for the answers. I said to one patient after explaining two possible courses of action, what would you like to do and she said:
“You’re the bloody doctor, you tell me, then she said, don’t bother I’ll see one of the others; you don’t know what you’re doing” (Geoff).

Such an angry patient response may not be typical of all patients. In this instance, by not returning to the GP (Geoff) the patient reaffirms their dissatisfaction with the consultation. Telling the GP not to bother is in itself dismissive. It appears from the follow up extract that the patient left the practice. This suggests a possible dissatisfaction with the practice overall as opposed to the individual GP. It is more likely that in this situation the patient would have changed her GP within the practice rather than leave altogether. When asked how he addressed this situation Geoff replied:

“The patient flounced out before I had chance to draw breath. I have never seen that particular patient since. A colleague told me that the family left the practice. That’s what we sometimes have to deal with” (Geoff).

Asked how this made him feel Geoff said he felt it was out of his control. What is clear from this experience is that one approach is not suitable for all patients. There will undoubtedly be variations in how much involvement in the decision-making
process patients wish to have. The extracts above demonstrate that while no patient participation in decision-making may be hierarchical and exclusive, GPs must consider patient choice. Involving those that do not wish to be part of the process can indeed backfire, as was the experience of Geoff. Patients may be unsure about what they want and have the right to change their mind. In addition it appears that the basis for examples of negotiation in these data suggest that such actions are built on similarity (the GP whose wife was in a similar situation as the patient) rather than difference and this in itself might be the basis for empathy and, therefore, action based on negotiation.

4.1.3 Managing Risks and Benefits of Prescribing

All GPs agreed that the benefit to the patient and the effect of the treatment were the most important factors when considering treatments. A significant finding was that none of the GPs considered the potential risk of *Clostridium difficile* when prescribing antibiotics, even in those patients who had a history of the infection. I asked all the GPs if they considered the risk of *Clostridium difficile* when prescribing antibiotics, particularly to patients taking a proton pump inhibitor medicine. None of the GPs believed there to be a correlation between the medicinal use of antibiotics and proton pump inhibitors with the development of *Clostridium difficile* infection. The following extract is a typical response:

“The honest answer is no, the fact that you’ve asked me suggests that you think I probably should” (Kevin).

Kevin is honest in his response but feels a little nervous at the realisation that this risk should probably have been a consideration. The following extract is a good example of a more confident response but John shows a real misunderstanding between a potential risk and a known side effect:
No, not at all. Diarrhoea is a known side effect of antibiotic prescribing but it doesn't mean the patient has C.diff. I don't think any of my patients have had C.diff, come to that,” (John).

The following is a further example that demonstrates the lack of understanding of healthcare associated infections and in particular Clostridium difficile:

“I think it all got blown out of proportion with that business in the South about ten years ago I think it was. I seem to recall they had some deaths from C.diff. It’s more for the hospitals to be worrying about than Primary Care. You don’t really see those types of infections in the community; well, rarely” (George).

Similarly, in the extract below James seems a little bewildered as to the question.

He clearly believes Clostridium difficile is an infection that only occurs in hospital:

“Odd question to ask, no it’s a hospital problem not a GP problem. You may want to ask hospital colleagues that question” (James).

Having established that Clostridium difficile was not a consideration, I asked the GPs if they thought they should consider the risk of Clostridium difficile. The following is a typical example of how this caused some GPs to feel anxious:

“Um, no, no not at all. Carol, I’m somewhat wary of this question, that’s twice you’ve mentioned C.difficile” (Paul).

When asked why he felt wary, Paul replied that he was obviously missing something.

The fact that I mentioned Clostridium difficile twice led him to believe it was significant though he did not understand why.

This next extract is representative of the total disregard most GPs had to Clostridium difficile as a real risk:

“No I don’t think so. We have not had C.difficile in the surgery. Oh, that’s where you were going with all the interest in diarrhoea. No, no problems on that score” (Steve).

Having now realised the reason for the question, Steve clearly feels confident in this response. Similarly, the next extract suggests considering Clostridium difficile as a risk is preposterous:

“Why on earth would I consider it (C.diff) there are far more important things to consider such as the known side effects and interactions” (James).
James recognises quite rightly that there are other aspects of prescribing that need to be considered but he completely dismisses *Clostridium difficile* as a considered risk.

As previously stated, all GPs considered the efficacy of drugs and with the exception of one GP, all considered mechanisms of actions and side effects of medication. Some of the GPs also recognised co-morbidities, co-medications, and the cost of the drug. The following typifies the risk and benefit considerations of prescribing:

“Without exception, I ask myself, do the benefits of this drug outweigh possible side effects? I also consider necessity and appropriateness and whether it is likely to interact with other medications that the patient is taking. Oh yes, obviously allergies particularly with antibiotics” (Peter).

Peter appears to use a mental framework habitually for considered risks and benefits. Some GPs spoke of feeling anxious and uncomfortable when prescribing, particularly in relation to possible side effects of drugs and drug interactions. They also felt some unease in relation to contra-indications and drug dosages. Perhaps the feeling of anxiety relates to a lack of knowledge, a lack of confidence in prescribing the drug, or a fear of possible litigation if prescribing goes wrong. The following is a good example that demonstrates the above points:

“I always ask patients what they are already taking but I always have concerns about interaction with other drugs and I must admit, I am cautious about correct dosages, particularly with children. After all, if you give the wrong dose of certain drugs there’s no second chance,” (Michael).

When I later asked Michael what he meant by no second chance, he explained that in some instances, giving the wrong dose could be fatal, particularly in the case of children. In such an instance, he felt he was powerless to put it right. Similarly, this next extract represents how prescribing occurs when the perceived benefits of the drug are greater than the risks:

“I look at the risks in relation to side effects of the drug and weigh them against efficacy of the drug, patient circumstance, that sort of thing and then I make my decision. Generally, if the benefits outweigh the risks I’ll go with it,” (Josh).
Josh feels happy with this decision. All GPs believed that early intervention often stops patients from becoming sicker and hence more vulnerable. GPs felt this was particularly relevant when they could not make a definitive diagnosis; I explore diagnostic uncertainty further in section 4.2.4. The following extract is a typical example of how a mental checklist is often used by GPs when balancing medication benefits against risks:

“I always do a mental benefit analysis for prescribing. Do the benefits outweigh the side effects and symptoms? Of course, I consider drug reactions, allergies, age, have they had the drug before; it’s a mental automatic checklist. It stands to reason the sooner you act the better it is for the patient” (George).

The extract seems to suggest that George also has a mental framework for checking risks against benefits of medication. For some GPs the decision to prescribe appeared to rest solely with force of habit, particularly when managing an uncomplicated infection. In such circumstances, these GPs only considered one drug. Whether or not the drug is suitable to the patient does not always appear to be acknowledged. The following extract is a good example of this:

“Take a UTI (urinary tract infection). I know immediately what I will prescribe for that; it’s a standard treatment. I don’t worry too much about anything else apart from making sure the patient gets the drug and feels better” (Geoff).

Geoff refers to a standard treatment, which implies that he uses the same drug for all patients irrespective of patient suitability, or possible new treatments. Geoff focuses on the patient getting the medication and meeting the patient’s expectation of feeling better. Geoff feels safer in taking the option to prescribe a tried and tested medication. The following is another example of how a GP takes no account of new drugs but appears to base prescribing on previous experience and habit:

“Nine times out of ten I know what to prescribe, I don’t really need to consider other drugs as I automatically use what I know and what I know works” (Paul).

I asked Paul how he would manage a patient where he may not know what to prescribe or know what had worked in other cases. He would not elaborate but there seems to be an over confidence in his response above. It seems when there has
been previous success in treating a condition; the familiarity is what automatically drives his prescribing. This makes him feel comfortable with his decision.

Many GPs highlighted how a good relationship with the patient is particularly important when the patient may be adverse to the prescribing decision and the biggest risk is that the patient will not take the prescribed drug. In the following example the GP fears that the patient will not take the medication:

“Sometimes, as odd as it may sound, the risk is the patient themselves because they don’t want to take an antibiotic even when they desperately need it. I always feel uncomfortable in those situations because as much as you might try to persuade the patient to take it you know chances are they will not take the drug even if they get it dispensed” (Kevin).

Such situations seem to cause Kevin to feel powerless, as he is unable to influence the patient to take a needed medication.

Summary

The findings suggest GPs responding to cues from patients when prescribing. GPs felt time constraints influenced both the decision to prescribe and the quality of their prescribing. Patients are sometimes involved in the decision making process but some GPs would never consider such an approach. GPs considered risks and benefits of medicines when prescribing antibiotics but they did not consider the risk of **Clostridium difficile** at all. GPs generally felt that general practice is isolating, particularly in single-handed practices and this added to the GPs’ feelings of stress, anxiety and powerlessness.

4.2 Theme 2 - Doing the right thing for patients

The focus of this theme is on feelings of power relating to prescribing and how GPs use their clinical knowledge to determine whether to prescribe or not. I also explore how GPs manage diagnostic uncertainty.
4.2.1 Feeling Powerful

During the process of validating the data with the GPs, a concern arose over the use of the word powerful. On reading the content of this sub-theme, these GPs agreed that I had truthfully interpreted their transcripts and they agreed that the sub heading *Feeling Powerful* should remain.

All these GPs related prescribing to feeling in a position of power. For some of the GPs the idea of power came from their reflections during the interview process. The GPs believed prescribing to be a powerful tool. They felt it gave them a position of power in the clinician-patient relationship because they had the skills, knowledge, and competencies to provide what the patients wanted and in most cases needed in terms of an antibiotic therapy. The following is a good example to demonstrate this:

“I hadn’t really thought about it until now but yes prescribing is powerful. There’s lots of talk of an equal working partnership between the GP and the patient but there never really can be. I mean how the patient can really be equal when the GP holds the power both in terms of their knowledge for diagnosis and their knowledge of medicines. What does the patient really bring to the table apart from their symptoms? Yes definitely a power tool” (Michael).

Michael dismisses the concept of an equal doctor patient relationship and assumes that the patient not only has a lack of knowledge but also is unable to contribute anything of value to the consultation. This is in contrast to the earlier example (Page 62) where Michael used his own experience to negotiate and support a good patient outcome. There is no indication that Michael used such a supportive approach with other patients.

Several of the GPs had no doubt that making the final decision to prescribe or not put them in a powerful position. All GPs agreed this top down approach reflected a prescribing decision made entirely by them. They all agreed there was minimal or no involvement of the patient in the decision making process. The following response is a typical example of this:
“I suppose it is power but I certainly don’t go around thinking I am powerful. I believe I have the necessary skills and knowledge to determine if medication is required. I have to have the advantage because the patient comes from a different starting point, they don’t always need what they think they do. That’s where the power comes in being able to say yes or no” (John).

John recognises that both he and the patient each bring something different to the consultation but John feels powerful as the ultimate prescribing decision is his. He implies that patients may have a misconception about what they need and often visit him with a pre-conceived idea of what they want. John himself though will make the ultimate prescribing decision. However, John becomes powerless because he cannot control whether or not the patient takes the prescribed drug.

In a more extreme version, the GP in the extract below seems to feel arrogantly powerful. However, it is unclear whether this is intentional:

“The final decision rests with me. I’m autonomous and also accountable, I have the power. Patients can request we can negotiate, sometimes they even demand but whether my signature goes on the bottom of that pad is my decision. That’s powerful don’t you think?” (James).

It seems the prescribing decision rests firmly with James and no amount of input from the patient will sway or influence the decision. In this instance, accountability and responsibility are a means of justifying this practice approach.

All GPs acknowledged that whilst in a position of power there is also a duty of care to treat the patient as clinically indicated. The following is a good example of this:

“Without sounding arrogant I have complete autonomy in my choice of medication. Patients seek me out because I have something they need. Whenever you find yourself in a situation where someone else can give you what you need the other person holds the power. I mean if I go to the bank manager I can tell him I’d like a mortgage or a loan but I can’t force his hand; he decides if I can have it or not. Obviously in medicine I have a duty to give the patient what they clinically need not what they think they need and that’s different” (George).

The analogy of the bank manager is interesting as it is used not only as a supporting statement but also makes George feels his approach is credible. GPs believed power
almost became an abstract tool for them to use when refusal to prescribe was deemed to be in the best interest of the patient. The following is a good example to demonstrate this:

“Patient expectations vary. Some patients are demanding they really are; they want an antibiotic and they can get quite anti when you try to dissuade them. This is where I hold the power card. In situations where an antibiotic is not a clinical option, I will not prescribe. It can be stressful, you don't want to be in a situation where you're almost arguing with the patient but some patients can get quite het up when you say no” (Steve).

The use of the term power card suggests some kind of game playing in a perhaps aggressive consultation situation. Steve feels a degree of stress when patients do not accept his clinical decision.

4.2.2 Using My Clinical Knowledge

Knowledge is intrinsically linked to power. All these GPs recognised that it was their pharmacological knowledge base that made them powerful. Knowledge as power can be used in both positive and negative ways. While the GPs expressed their desire to keep updated and practice from a strong evidence base some were concerned that other pressures often prevented them from attending educational or developmental sessions. The following extract typifies the experience of all of the GPs who agreed there were many competing demands on their time. Demands included the changing NHS, an increased workload, and a more informed patient population. All GPs believed these pressures had a negative impact on their capacity to keep up to date particularly with prescribing and new medications:

“I have a professional obligation to treat my patients effectively and that means keeping my knowledge base up to date and that’s tough in the current climate with so many pressures on the GP. We have time pressures that impact on our ever increasing workload and patients seem to know and want more and more,” (Josh).

Josh recognises the need for evidence based practice. He appears to feel that keeping updated is a burden that adds yet more pressure. The use of the word
obligation suggests he feels he has no choice and must remain up to date whether
he wants to or not. Several GPs referred to their medical knowledge and the ways in
which they can use it to keep the power balance in their favour when prescribing. The
following extract is a good example of this and suggests a feeling of power:

“It’s up to me to decide if I want to prescribe. I decide if it’s appropriate or not
and what that medication should be, if anything at all. The patient doesn’t make
that decision I do. (James).

Again, this is another example that the GP does not take account of patient choice;
James is the sole decision maker. The tone of the extract suggests James would feel
it preposterous to consider any other option. In contrast, the next extract is another
example of GP awareness of the power of knowledge:

“Knowledge is power there’s no doubt about that. It can be used in a positive
way using your knowledge and expertise to empower patients or as in some
cases in a negative way. By not sharing information or knowledge, it can be
seen as I have the power and you don’t. I want to do right by my patients, as
I’m sure most doctors do. I’m here to improve health outcomes for those within
my practice, prescribing is a powerful tool to support that” (Michael).

Michael recognises that the knowledge base of prescribing supports good decision
making which in turn improves health outcomes, however, Michael clearly feels
ambivalent about this given his earlier comments (Page 69). He also feels that by
sharing knowledge he is empowering patients to make informed decisions. There is
an implication that used negatively knowledge becomes a powerful weapon almost a
good or bad tool depending on who is using it and the situation it is being used in.
The following is yet another example of how GPs use their clinical knowledge to
make effective clinical decisions:

“I always without exception consider a range of treatment options and then
decide which is the most suitable to address whatever it is I’m presented with. I
have to use my clinical knowledge and to do that effectively I have to keep
myself up to date” (Steve).

It seems that not only do GPs keep themselves updated but patients also now
have a greater understanding and knowledge of medicine. Most GPs believed the
Internet has given the public access to information that had never before been
available to them. Managing this new knowledge base of patients is not without its challenges. Several GPs said they did not feel threatened by this and that it did not adversely affect either clinical or prescribing decisions; as the following example demonstrates:

“Nowadays I often have the internet thrown at me. Patients seem to think they know best because they’ve read up on something, it goes back to the old saying a little bit of knowledge is a dangerous thing. Of course, what they don’t have is medical training or experience. I don’t particularly feel threatened by that as I know I am the only one with a credible knowledge base, I don’t let it affect my clinical decisions or my choice of drugs” (Geoff).

Geoff believes he is the only one with any credible medical knowledge; he feels irritated that patients perceive they have expert knowledge because of searches undertaken on the Internet.

All GPs talked of how they build up an extensive knowledge base. Many GPs talked openly about how keeping up to date with evidence based practice results in a more confident practitioner. The following is a reflection of this:

“Once you have the foundations for prescribing you build on them. One’s knowledge base becomes extensive but as new medications came into play older medications are no longer prescribed, as there is usually some evidence be it through a guideline or policy that dictates what should and shouldn’t be used. Knowing you are following guidelines and policies makes me feel good about what I do. I know if I was challenged I have evidence for my prescribing” (James).

The extract suggests James feels safe by staying within the parameters of clinical guidance. He feels confident that should his prescribing come under critical scrutiny he has not stepped outside of guidance parameters and has an evidence-based rationale for his prescribing. The extract suggests that feeling powerful may only apply to the doctor-patient relationship because not stepping outside the boundaries of clinical governance also makes James feel powerful.
4.2.3 To prescribe or not to prescribe

All the GPs recognised that being the ultimate decision maker for prescribing was powerful particularly when deciding whether to prescribe or not. When deciding on a treatment there is always the option to do nothing. However, these GPs suggested they would only do nothing when there is absolute certainty that there is no need for medicinal interventions. The following response demonstrates this point:

“Yes, of course there is always the option to do nothing but you have to remember that choosing to do nothing may well come back and haunt you. Can you defend your decision to do nothing? If the answer is truly no then you are duty bound to do something. Doing nothing always makes me a little uncomfortable” (George).

The statement above suggests George feels obligated to act, as not doing so causes him to feel uneasy. Many of the GPs felt patients had expectations of them but GPs also had high expectations of themselves. It seems these factors often made it difficult to refuse patients a prescription even when it was not always clinically indicated. Several GPs felt they should do something or prescribe something in order to show understanding and empathy. Some GPs seemed to think that issuing a prescription implies an empathetic approach as the following typical response demonstrates:

“I owe it to the patient to do something, yes. Sometimes they really don’t need anything but they want something and you know that psychologically they will feel better knowing you have listened and given them the antibiotic. I feel more uncomfortable when I don’t prescribe than when I do, even when I know it would be considered as clinically inappropriate. It’s a benefit to the patient,” (Michael).

Michael appreciated he has a duty of care to the patient but he fails to take account that not prescribing may too be in the best interest of the patient. Michael seems to assume that prescribing will address psychological needs but it is not clear if, or how, he tested this perception. Michael recognises that at times patients do not require clinical intervention but he feels more comfortable prescribing than investing time explaining to the patient why they do not need a prescription. Doing nothing makes
Michael feel uncomfortable, which may suggest this is habitual practice. Breaking the habit may be the true cause of his feelings of discomfort rather than failure to meet the alleged psychological needs of the patient.

Similarly, the extract below is a good example of how in order to show a caring empathetic approach to patient care the GP has to do something:

“I feel I have to act, I have to do something to minimise patient anxiety and discomfort. I don't want the patient to think I don't care. I want the patient to know I understand and that I'm trying to make it better. I feel uneasy when I can't do that” (Peter).

As in the previous extract, Peter also feels a sense of anxiety if he does nothing. He wants the patient to know he is both caring and understanding but believes this can only be achieved by doing something, whatever that may be. It seems the notion of actually talking to the patient to express understanding or concern is not considered.

Many GPs suggested that deciding not to prescribe is both challenging and stressful particularly when they have prescribed before for the same symptoms, or condition. Setting perceived limits on certain drugs, while clinically appropriate and more beneficial to the patient is often against patient wishes and a cause of discomfort for GPs. For some GPs, the repercussions of patient dissatisfaction and wanting to keep the patient happy were drivers for prescribing as the following typical example demonstrates:

“I've been caught out a few times when I've thought shall I or shan't I prescribe and then I have. The patient has come back with similar symptoms and I've decided in that instance not to prescribe. Patients get a bit disgruntled. I try not to get myself in that situation because it's challenging and stressful especially when the patient says; you gave it to me last time. You can't really turn round and say yes but I probably shouldn't have” (Josh).

The desired outcome for Josh is to try to make a decision that is acceptable to all parties. The first line of the extract implies Josh feels he is doing something wrong and having prescribed in the first instance now feels he must continue to do so. Having set such a precedent, he feels it is difficult to change such practice without
feeling stressed and possibly upsetting the patient. A form of guilt rather than open and honest communication may drive this prescribing trend. This places an unnecessary self-inflicted stress on Josh. Similarly, finding a solution to suit all parties appears to be the desired outcome in the following extract:

“I weigh up all the factors when making a decision to prescribe or not. Yes, patient expectation comes into that. I try to come to a decision that is acceptable to both of us. I feel comfortable with that” (Geoff).

What is not clear is how much patient expectation drives the final decision and whether meeting such expectations is what makes Geoff feel comfortable.

Two of the GPs described a situation where there was a distrust of the patient; the following is a good example of this:

“I had a situation with a patient who kept coming back; it made me feel uncomfortable because initially I had prescribed an antibiotic. She never looked particularly unwell and always seemed bright during the consultation. After the fourth or fifth time, I wouldn’t prescribe anymore and suggested further investigations. She never seemed to suffer from the problem after that. I never got to the bottom of it but it was odd. I did wonder if she was giving the drugs to family members, whatever it was she was not being totally honest with me” (Steve).

Steve has suspicions of how the patient is using the prescribed medications but does not feel able to explore these concerns with the patient. This is possibly because Steve feels uncomfortable in such a situation. While Steve chose not to prescribe, he did not unearth the evident patient problems. This is interesting in terms of Balint’s work because a Balint group may have helped Steve to understand his feelings.

Several GPs discussed patients that went from one GP to another to try to get what they wanted. This was recognised as a cause for concern, as it could be a cry wolf scenario with the potential to miss a true diagnosis. The following response was typical of all:

“The problem is patients want this and that when there are no clinical indications, it’s difficult to say no sometimes. I always worry that one day the
patient will really have a health problem and due to the past history I'll miss it" (John).

John is concerned that if he does not take the patient seriously he may miss a critical issue and therefore feels the safest option is to prescribe. Sometimes it seems the decision to prescribe is based on whether or not a patient is considered pleasant, rather than on the patient’s clinical need. Managing such relationships must be challenging but patients have a right to health care irrespective of how pleasant they are. The following is a good example to highlight this point:

“There was one man in particular who comes to mind, he wasn't particularly pleasant. He went round us all, he played us off against each other, he knew what he wanted and would see someone different each time to try to get it. None of us would prescribe for him. I always felt I'd got one up on him. This went on for a while until he gave up and left the surgery” (Kevin).

In this instance there appears to be an element of game playing which results in one-upmanship for Kevin and his colleagues. It is unclear whether clinical facts formed the basis of the decision not to prescribe. The desired outcome of the GP may have been realised with the patient leaving the practice but certainly, this would presumably have been a poor experience for the patient. In contrast, several other GPs described how on occasions they had not particularly warmed to a patient. They all believed this had never affected their prescribing decisions. The following typifies their responses:

“We are human beings, you can’t take to everyone. It would be an abuse of my position to base my decisions on whether I liked a patient or not. I'm not here to like or dislike patients I’m here to do a job. If there is a health need I will address it, if that means prescribing then I will” (Josh).

Josh demonstrates a professional approach and professional awareness; he appreciates his professional responsibility and quite rightly feels accountable for the management of patients’ health care needs.

Some GPs shared their experience of how perceived unreasonable demands by patients had affected their decision to prescribe. They stated they would never withhold treatments or medications if it would adversely affect the patient. Again, this
response demonstrates how patient personality and behaviour has the potential to affect prescribing:

“I had a patient that irritated me. He would come in and be over familiar. He’d tell you what to do and what to give; I got a degree of personal pleasure saying no” (John).

It is not clear whether John had clinical justification in saying no to the patient but his response suggests that he gained a sense of personal satisfaction from this situation.

4.2.4 The Experience of Diagnostic Uncertainty

All GPs described the feelings of unease when managing diagnostic uncertainty because of the potential to misdiagnose. All these GPs spoke of the uncertainty when a diagnosis was not possible yet the pressure to act to manage patient symptoms was great. This was one of the biggest areas of concern for them all and they believed the experience of diagnostic uncertainty was worse within primary care.

The following extract is a typical example that highlights this dilemma:

“I find this particularly tricky. I feel I should do something but then I worry that I may be masking a serious illness if I do prescribe. I do tend to prescribe when I’m not sure but I sometimes feel I’m taking a risk, particularly with some of my elderly patients and small children” (Paul).

The medical instinct to act to alleviate unpleasant symptoms is strong, particularly when dealing with vulnerable groups such as children. Paul feels some mental anguish in such situations. He feels torn between alleviating unpleasant symptoms and the potential risk of hiding a serious condition with prescribed medication.

GPs described how prescribing for both the elderly and young children, made them feel uneasy. Some spoke of uneasiness with diagnostic uncertainty only with children. The following is a typical response of the complexities of diagnostic uncertainty:

“Elderly patients are often complex, they have co morbidities and it’s difficult to always know what’s going on. The trouble is you prescribe something and because they are usually on other medications, one drug knocks out another
“and before you know it you’ve sorted out one problem but unintentionally created something else” (Michael).

Michael acknowledges the complexity of co-morbidities and feels managing elderly patients is sometimes difficult. The extract highlights how, in an attempt to alleviate one set of symptoms, one can inadvertently create another, which is often referred to as ‘iatrogenic disease’. Another cause for concern is managing sick children and GPs believed this concern was representative of all GPs. There seems little doubt than when faced with a sick child, GPs would prescribe as this next extract demonstrates:

“Children are always a worry, they move quickly from one state to another; if it’s from sickness to recovery, all ok but they can and do rapidly deteriorate. I feel fairly confident in saying most GPs will prescribe for a child or refer them on quickly” (Josh).

Josh feels worried by the speed in which children can deteriorate. His worry may be exacerbated when dealing with the youngest child age group because the child is unable to articulate how or where they feel unwell. The following extract is another example of how diagnostic uncertainty causes GPs to feel anxious particularly when dealing with children:

“I have sleepless nights where children are concerned, you can never be too careful, I’m never complacent. I always feel the need to do something but sometimes you don’t know if you’ve done the right thing because you’re not sure what you’re dealing with. I tend to do lots of follow ups with the family” (Steve).

Steve feels there is a need to respond, he appreciates that advocating interventions is often difficult when the source of the problem is unclear. The extract highlights how such situations affect GPs. It appears to be difficult to determine what action to take when hampered by uncertainty. It seems GPs do not leave their major concerns at the practice; they remain with the GP even when off duty. Feelings of anxiety and uncertainty related to managing sick children appear to impact on the ability to sleep. Not sleeping may result in tiredness and an inability to focus fully on practice the next day. The margin for human error then widens.
The following is a further typical example of how when faced with uncertainty GPs would act:

“Most patients come to you because they do not feel well. You can’t always make an immediate diagnosis without further tests or profiles. You know you should do something to manage unpleasant symptoms but you don’t really have much to go on. Would I prescribe in this instance, yes I would” (Geoff).

Geoff feels prescribing would benefit the patient in terms of symptom management but his perception may not be real. Knowing he has acted and prescribed may be more reassuring to Geoff than it is to the patient. The consensus was in times of uncertainty it is better to err on the side of caution and prescribe than do nothing. The following extract is a typical example, which highlights how such situations caused feelings of anxiety for both patient and GP:

“It gives you a very uneasy feeling when you’re not sure what you’re dealing with. In some cases I have given a delayed prescription and in other cases I’ve given a prescription to be started immediately depending on what I’m presented with. It gives the patient a bit of reassurance too I think,” (James).

Issuing a prescription, even a delayed prescription evokes feelings of reassurance for both James and the patient. Again, the following is another example of how uncertainty is the driver for prescribing:

“If I’m not quite sure I’ll usually prescribe, particularly if the patient says, I’m going on holiday or I’m out of the country for a few days. I feel like I’ve done something and the patient doesn’t have the worry of trying to get medical help elsewhere if the problem worsens” (Peter).

Adopting such an approach gives reassurance to both Peter and the patient. In another example, the GP shared an experience that highlighted caution in times of uncertainty. Some of the caution links to the experience of a colleague:

‘We tend to get told off for our so called inappropriate prescribing. Oh, it costs money? Well, it costs a lot more money if the patient ends up in ITU (Intensive Therapy Unit) because I did nothing. Look at the cost factors there, to the patient and to my reputation. That might seem extreme but a colleague of mine sent a patient away and the patient died. It didn’t end well for my colleague either. No it’s human nature to err on the side of caution’ (George).

George implies that if faced with a similar situation all humans would react the same. This implication does not take into account any calculated risks. George
recognised that as well as financial costs there were other potential cost considerations both to the patient and to his own professional reputation. George appears to feel frustrated by the financial constraints of the system, a frustration that may be exacerbated by the experience of a colleague.

All GPs spoke of the difficulty in carrying out diagnostic investigations in primary care. Some GPs had experienced diagnostic uncertainty even when investigations had been undertaken; such situations are a cause of anxiety as the following typical example demonstrates:

“It’s difficult for us, (GPs) we don’t have the luxury of being able to undertake many investigations in the practice and I’ve had several cases where the patient has been investigated and yet it was still not possible to make a diagnosis. You’re prescribing in the dark, it’s every clinician nightmare. It’s stressful; you just hope you’re not missing something” (John).

Diagnostic uncertainty is a cause of stress for John. He refers to the luxury of undertaking investigations, which suggests that having such a luxury would be beneficial in terms of feeling clinically reassured. Clinical investigations support diagnosis and subsequent treatments but may at times be inconclusive. John seems to feel concerned that he may miss something of importance, which exacerbates his feelings of anxiety. Other GPs described how the stress of diagnostic uncertainty is cumulative.

Not having a definitive diagnosis does cause GPs to feel stressed. There is further stress related to the need to act and prescribe for an unknown condition and the following typical response reflects this:

“It’s bad enough that you don’t know what the problem is, you worry that you could be missing something, then of course, you have to do something. The patient expects you to do something. What do you prescribe? Sometimes you might as well get the BNF (British National Formulary) and stick a pin on any page and go with that because you often have no true indication of what you are prescribing for. That makes me feel uncomfortable; it’s a double dose of stress” (Geoff).
The tone of the statement suggests that such situations are a burden and rather troublesome for Geoff. It highlights how sometimes clinicians can feel out of their depth when dealing with unfamiliar situations and uncertainty. The potential to get things wrong in such situations is great and it is not without good reason that Geoff feels stressed. In challenging situations such as this, it appears that Geoff does not consult with the other practice partners. Perhaps Geoff feels this would show a weakness. As discussed in 4.1.1, one of the benefits of practicing within a partnership organisation must be access to professional expertise, knowledge, and support. Some GPs have previously spoken of how this helped alleviate some of the feelings of discomfort associated with this diagnostic uncertainty.

All these GPs appreciated the seriousness of diagnostic uncertainty and all could recall at least one experience they had heard of where a wrong or missed diagnosis had led to a patient death. They believed this added to their own feelings of anxiety when dealing with such patients. The following extract is a good example to demonstrate this:

“I remember when I was a trainee GP one doctor was way off beam with his prescribing for a patient where the diagnosis was unknown. The drug was in fact exacerbating the problem and the patient died. Of course, this only came out after the patient’s death. That doctor was devastated; he went on sick leave and never came back. That has stuck with me. It could be any one of us. That’s a big burden to deal with” (James).

An experience encountered when a trainee has left James with a lasting impression, which has subsequently influenced his practice. James feels the burden of uncertainty is a heavy load to carry. The situation is more real for James because he has a powerful experience to support it.

All these GPs spoke of a range of health care concerns where a specific diagnosis is not possible and all believed there is paradoxically greater pressure for them to
respond to the symptoms. The following extract is an example of this point:

“It’s definitely more difficult for us in General Practice. We tend to see disease in its early stages; diagnosis and treatments decisions are made at lower levels of probability” (Steve).

Steve theorises why it is more difficult to prescribe in general practice. There appears to be a level of acceptance of the situation and recognition of how things are in general practice. Although Steve suggests managing uncertainty is tough, it does not appear to be a particular cause of anxiety for him.

Summary

GPs believed prescribing was a powerful tool. However, to prescribe efficiently and effectively, GPs need to keep up to date with available evidence. While there was always the option to do nothing GPs agreed that they felt more comfortable when they prescribed particularly when dealing with children and the elderly. Diagnostic uncertainty especially in the most vulnerable groups of patients was a concern and evoked feelings of anxiety and discomfort.

4.3 Theme 3 - Managing Expectations

The focus of this theme is on GPs feelings when managing the expectations of patients and their families. I also explore the role of the pharmaceutical industry in prescribing decisions.

4.3.1 Managing Patient Relationships and Expectations

GPs try to establish and maintain a good relationship with their patients (section 4.1.2). Within the NHS, all national policies are placing far more emphasis on putting patients at the heart of decision making and driving forward the objective of “no decision about me without me” (NHS Operating Framework for England 2011/12).
Some of the GPs felt such directives placed further pressure on them, particularly when they perceived that patients were determined to obtain medications via a prescription. The GPs often found it difficult to persuade patients that they do not need therapeutic interventions; suggesting tensions can build between them and their patient. They believed such situations can and in some instances does destroy the doctor-patient relationship. Sometimes the damage is beyond repair, which can result in damage to their reputation and I explore professional reputation further in section 4.4.1.

There was a consensus amongst the GPs that prescribing antibiotics is one of the most uncomfortable yet most frequent prescribing decisions they have to make. They all felt patient pressure contributed to the discomfort. GPs believed the most demanding patients had the greatest influence on their prescribing decisions as the following response demonstrates:

“Often, if a patient has had an antibiotic for a condition in the past, they may come back and ask for it again, even when there are no clinical symptoms, or at least very few. They say things like, “I think it’s coming back; this is how I felt before.” You either have a disgruntled patient if you do nothing or you prescribe the antibiotic. I have prescribed in times like these,” (Michael).

Michael’s prescribing seems to link to habit rather than clinical symptoms. It may be a mechanism to save face having prescribed before and may prove easier than saying no. Maintaining the status quo and prescribing it seems makes Michael feel more comfortable than risking a challenge from the patient.

Several GPs spoke of the effectiveness of “delayed” prescribing, waiting to see if symptoms worsened or indeed improved. The following response highlights this course of action:

“I have written a prescription with the directions that if the symptoms get no better or worse, then cash in the prescription. That works. That way you’ve
covered yourself and the patient has a fallback position if things don't improve” (Peter).

The response demonstrates how such an intervention can be satisfactory for both parties. The patient receives a prescription should they need it and Peter feels he has fulfilled his duty of care to the patient. The extract highlights Peter’s feelings of anxiety in relation to managing his professional accountability in such situations. It also highlights how Peter seeks a resolution agreeable to the patient and himself.

When faced with diagnostic uncertainty it seems delayed prescribing is not only a positive outcome for the patient, but also allows the GPs time to think through the case before seeing the patient again. The following response is a good example of this:

“One of the benefits of general practice is I can see a patient again quickly if need be. Giving the patient a prescription just in case often makes the patient feel you have done something, it covers them over a weekend or bank holiday. It gives me a bit of thinking space too which is good in cases of uncertainty” (Josh).

Josh assumes that patients can be seen quickly but this may not be the case with current general practice appointment systems. There is often a lengthy wait to see a particular GP. By issuing a prescription, Josh feels he has responded to patient need while buying himself time for reflection and further thinking. In contrast, several other GPs felt delayed prescribing gave the patient the impression that they did not know what they were doing and therefore were incompetent. The next extract is a good example to demonstrate this:

“I don’t like delayed prescribing. If you know what you’re doing why delay the prescription. It’s like telling the patient, I don’t know about this but I’ll make a stab at it. It would make me look and feel incompetent, don’t you think so? Why would you bring that on yourself?” (John).

This suggests that John believes a doctor should always have the answer and not doing so is a professional failing. Uncertainty for John makes him feel uncomfortable and he perceives it as a self-inflicted incompetence. This may demonstrate that John does not feel confident in being fully open with the patient. John believes patients
expect him to have all the answers. An important point is that the perceived incompetence comes from John himself not the patient.

Other GPs felt they were not really in control of such a situation. Many suggested that if a patient did not receive the prescription they wanted they would seek advice from another practitioner; even if that meant a lengthy wait at the local accident and emergency department (A & E). The GPs’ experiences suggest that once a patient is familiar with the NHS systems they can use this familiarity to attempt to get what they want. The extract below is a typical example that highlights even when patients are involved in the decision making process if the outcome is not to their liking they will pursue treatments elsewhere:

“It’s difficult, you make a clinical decision and you can tell the patient is not happy with the decision. I then give the patient the rationale for why I’ve come to that decision. They don’t always say much at the time but the next thing you know you get a notification that the patient was seen by the out of hours team or through A&E. I can’t control that. Some patients will go all out to get what they want even if it’s not what they need” (Kevin).

Kevin feels frustrated by the behaviour of the patient because he feels the situation is out of his control. He recognises that the patient appears dissatisfied yet does not explore why. This may be due to Kevin feeling powerless to deal with the problem, time constraints of the consultation, or both. Similarly, the following extract demonstrates a further reflection:

“There are occasions when I’ll prescribe because I know full well that if I don’t they will go elsewhere. Several of the patients here just go to A&E if they can’t get what they want. Patients learn how to play the system,” (George).

As with the previous GP, George also feels that the situation is beyond his control. Prescribing in this instance appears to be determined by the need to prevent the patient attending another department, particularly accident and emergency. A prescription from George may go some way to prevent this. George suggests that
some patients see the health system as a game, which they learn to play in order to get what they want and this is a cause of frustration for George.

The extract below is another example of perceived game playing within the practice:

“With patients now belonging to a practice as opposed to individual doctors, there can be a play off. Patients are astute at knowing who will give them what they want” (Paul).

Paul implies a feeling of hopelessness and appears to accept such practice as he feels he has no control over the situation.

All GPs believed that the Internet has increased the knowledge base of the public on a plethora of subjects including general medicine. Interventions and treatments available in countries such as the United States of America and Canada are often starkly different from those afforded to patients under the NHS. Many of the GPs had experienced pressure from patients who want revolutionary treatments found through search engines on the Internet. It was not possible to determine if this was a real or perceived patient pressure. The threat felt by the GPs in relation to the professed enhanced knowledge base of their patients was real. The following extract is a good example to highlight this:

“Years ago as a doctor I wasn’t questioned. Patients got what I gave them; there were no challenges. Now they come in and want this and that having spent hours on the Internet. There have been times when I’ve thought here’s my chair you obviously know more than I do” (Kevin).

Kevin believes that he knows best. More informed patient seems to make him feel threatened. Perhaps Kevin lacks confidence in his knowledge; alternatively, he may be concerned that the patient may have more up to date medical knowledge from other countries than he does. Kevin refers to practice from years ago which may suggest a lack of professional development. The increased knowledge base of the patient may exacerbate Kevin’s feelings of vulnerability. The following is another example of the impact of the Internet. The GP here acknowledges the power of the
Internet and the ways in which patients' confidence has increased during consultations:

“There’ve been a couple of instances when I’ve been presented with a folder full of articles printed from the Internet. One patient even said well doctor this is what’s wrong with me and on the next page is what you need to do. I hadn’t even heard of the condition let alone treated it. Trying to persuade that patient that I needed to order my own tests took some doing” (Michael).

Michael feels exasperated when he is presented with such information.

The following response highlights the added financial pressures posed to GPs. Such pressures are not a consideration for patients who understandably focus their attention on moving from a state of ill health to a state of wellness:

“Oh the joy of patient pressure! Patients come in and want what they’ve read on the Internet. Patients don’t care about the financial cost of medicines, they want the best, they want what will make them well, and they’re not interested that we have to work within a financial envelope,” (Josh).

Josh feels a tension in relation to patient pressure particularly when the patient has a course of action in mind. The extract appears to imply patients are selfish because they only consider their own wants and needs, and do not concern themselves with financial costs.

All the GPs perceived the pressure from patients was greater when patient requests for antibiotics were clinically unfounded. All believed that persuading patients that they do not need a prescribed medication is not without problems. Many GPs spoke in detail of the changing NHS, the constant drive to reduce costs while improving patient outcomes. GPs spoke of the tension in trying to balance the doctor-patient relationship while managing prescribing budgetary restraints. Some GPs suggested patients perceive prescribing policies as an excuse not to advocate certain treatments or medicines. The following extract is a good example to demonstrate such points:
“We are practicing in particularly challenging times; we have to provide more for less. I’m finding it hard to keep patients happy and at the same time work within the parameters of policy and finances. I’m not sure the three things really work together. There’s never enough money, the policies are getting more and more prescriptive which gives me less freedom to practice. This can affect the patient relationships. They don’t care about your budget; they certainly don’t care about policy. Some see it as a shield for us to hide behind” (James).

The extract highlights the feeling of stress for James, which is associated with trying to balance patient satisfaction with clinical effectiveness, and finances. James believes that the concept of quality up, cost down, better for patients is an unachievable aspiration.

Many of the GPs believed part of their role was to negotiate with patients. Others felt the process was tiresome, time consuming, and demeaning. Interestingly these feelings were not unique to the GPs who had been in general practice the longest.

The following extract is a good example to demonstrate this point:

“Times have definitely changed. I used to make a decision and that was that, accepted by the patient. Not anymore; now I have to justify myself to the patient. I have to try to persuade them to do what I know is right. None of this is factored into consultation time, its labour intensive. I mean if you take your car to the garage you trust what the mechanic tells you, you don’t ask for chapter and verse and start negotiating with him. It’s tiresome, it’s like a silly game, and I’m too busy for that “(Geoff)

The extract suggests that Geoff finds the challenge of today’s practice tedious. He uses the analogy of a car mechanic to labour the point that his word should be accepted without question or challenge. Geoff feels there is little benefit in involving patients or giving a rationale for decisions, suggesting instead that following doctor’s orders would be less time consuming. The suggestion that he may be expected to negotiate with patients makes Geoff feel irritated. It appears that his time is too precious for seemingly tiresome trivialities. Likewise, the next extract is another example that also shows irritation at having to enter into any discussions with the patients, suggesting doing so is shameful:
“How humiliating having to enter into negotiations with the patient. I’m trying to help them and yet I have to almost sell my clinical decisions to them. It’s demeaning to the medical profession what ever happened to the expert knows best?” (Steve).

It seems Steve would prefer to return to the doctor knows best concept. Steve believes patient participation in decision making is degrading to his profession. He feels incensed at the idea of having his judgment challenged.

All these GPs described the pressures of driving out inefficiencies from primary care. They felt the emphasis to reduce hospital referrals put added pressure on them to diagnosis and treat more patients themselves. The following is a good example of yet another added stress:

“Now we’ve been told that GP referral rates are too high, we will bankrupt the system I was told. That puts another pressure on us. I only refer when I either need another opinion or if it’s outside the scope of my competence. Now we have to work it through for ourselves, that’s fine until something goes wrong” (John).

John is feeling the pressure of the many demands placed on primary care physicians. Similarly, the next extract is a further example that highlights the frustration of alleged restrictions that impact on general practice:

“They keep targeting primary care with all this talk of inefficiencies but there are inefficiencies in other parts of the system that impact on us. Poor discharges for instance. If I don’t know I shouldn’t be forced to make a diagnosis. I should be able to refer. I’m a generalist not a specialist” (Peter).

As a GP in primary care, Peter feels victimised, suggesting that other inefficiencies remain unchecked. Peter appears to have misunderstood the concept of specialist referrals because he wrongly believes that he must make all diagnosis in primary care.

There was a consensus that as generalists G.Ps needs to refer some patients for a specialist opinion, even when the referral may lead to no more than a one off appointment. Some GPs described the increasing pressure they felt when
constantly being told to reduce inappropriate referrals. The following is a typical response that highlights the frustration felt when pressure builds within the system:

“If I thought the referral was inappropriate I wouldn’t have referred. It is obviously outside my knowledge sphere or I would have dealt with it myself. I feel the powers that be, the PCT, the commissioners are expecting us to have more and more specialist knowledge to see, diagnose and treat patients. We receive the flack when it goes wrong. Sometimes I feel I can’t do right for wrong in these circumstances” (Paul).

It is evident that Paul feels he is in a no win situation and believes he will be blamed if things go wrong. Paul recognises his knowledge limitations and considers his referrals are appropriate.

Many GPs spoke of being a caring professional and they believed an empathetic approach was key to this. The following extract is a good example that highlights how for some general practitioners empathy is borne from sharing an experience, albeit the experience of potential ill health:

“Patients don’t only expect me to be an expert they expect a doctor to be a caring person. I do lie awake at night and worry about some of my patients. I’ll openly admit I didn’t used to until I had a health scare myself. I was anxious I wanted an immediate referral. I didn’t want to wait and yet these guys are my colleagues. If I feel like that I know darn well the patient wants me to get them to the right person wherever that may be, in a timely fashion, they don’t care that referral rates are up” (Michael).

Michael has firsthand experience of patient anxiety. In this instance, he wants to refer because he understands that the patient wants to be seen by the right person, in the right place, at the right time. Michael’s own experience has increased his awareness of the anxiety patients often feel while waiting for a specialist referral and diagnosis. Walking in patients’ shoes seems to increase feelings of empathy and understanding.
Some GPs saw “colluding” with the patient as counterproductive. GPs believed that giving patients what they want may reinforce negative behaviours that lead to costly prescribing that have no real benefits. The following is a good example of this:

“I stand my ground. I will not be forced to prescribe on a whim. It’s difficult and I understand why one may be tempted to do it but it is a pointless exercise that serves no purpose other than reinforcing to patients that they need a medication when they clinically don’t. I don’t want patients thinking we can achieve miracles, with medicines. When they find they’re not working back they come requesting something else. No, I refuse to be drawn into that game” (George).

George’s tone appears aggressive which suggests patients may come up against a barrier when dealing with George in the clinical consultation. The response demonstrates either a lack of faith in medicines or more likely the realisation that not all medical conditions are curable. When I asked George how he managed situations such as this he suggested that he educated the patients and negotiated other courses of action that did not require a prescription. Trying to find out the patients’ objective may be a starting point for negotiating any compromise. The following extract demonstrates these points:

“It’s my job to help patients understand what we can and can’t achieve with modern medicine. I do negotiate with the patient but I know I am in the driving seat so to speak. I will do what is clinically justified and in these circumstances I do try to get the patient on board with this. I try to find out what is it that is wanted and why” (Kevin).

Similarly, other GPs believed that prescribing for self-limiting infections reinforces patient beliefs that antibiotics are a cure all. GPs suggested prescribing in such situations encourages patients to see the doctor if similar symptoms reoccur. The following typically represents GP responses:

“Many patients do seem to think that antibiotics will cure everything known to man. Prescribing an antibiotic for a cold or minor sore throat, to me, reinforces this belief. The upshot of this is that every time the patient gets a cold or sore throat they come back. You have to be consistent, if you’ve prescribed first time round you end up prescribing again and so it goes on. I’d rather get it right first time and say no an antibiotic will not help you, but paracetamol, fluids etc, will” (John).
John feels a need for consistency, which prevents the patient from receiving mixed messages. John feels he may be caught in a vicious circle of poor prescribing habits if he is not clear with patients from the outset. John recognises giving other clinical information such as increasing fluid intake is a good alternative to prescribing without clinical justification.

Several GPs said patients seem to think all consultations should end with a prescription. While this may be a natural conclusion to a clinical consultation, it was not the only conclusion. To give advice was also an outcome in itself and not needing medication was a positive indicator of health. The extract below is a typical response that implies that patients should be grateful for good health:

“You would think a patient would be happy to be told that while they are unwell, an antibiotic will not make them better. This often is not the case they think you haven’t done your job properly unless they go away with something. It’s almost like they can confirm that they’re ill. It’s just another stress we have to deal with” (Kevin).

It seems Kevin perceives that patients revel in the sick role and seek confirmation of their ill health by requesting a prescription. Kevin feels frustrated trying to deal with yet another hassle.

4.3.2 Managing Family Relationships and Expectations

All the GPs agreed that families could be difficult to deal with particularly in relation to the most vulnerable patient groups such as the elderly and children. The following extract is representative of all GPs who spoke of the frustrations of trying to do the best for patients, but found their actions are in contrast to the wishes of the family:

“I fully understand the concern for loved ones I really do but I just wish that sometimes common sense would prevail. Families can get agitated if you don’t act in the way they think you should or treat with the medicines they want you to prescribe, it’s frustrating” (James).
The frustration felt by James is obvious. He is trying to be tolerant but appears to feel exasperated by the apparent unreasonable demands of family members. There is a suggestion that when families face the illness of a loved one, their expectations of health professionals are not always rational. The next extract is a further example that highlights similar feelings of GP frustration:

“I'm not going to force a statin onto a 90 year old patient because the family is concerned that the mother has a raised cholesterol level. Dealing with families like that can be an unpleasant experience. Families for the most part have the best of intentions for their family members but it is not always the best course of action” (Geoff).

Again, Geoff believes that sometimes, family expectations are not realistic. When the opinion of the GP differs to the family view conflict can occur. The statement implies that managing family members can sometimes create feelings of hostility for both parties. While families may want to do the right thing this may not always be the case. Geoff tries to take a pragmatic approach and does not bow to family pressure when the situation becomes heated.

The GPs spoke freely of how fragile relationships with families can be. The following extract typically highlights how not responding to family wishes can affect relationships particularly when the family member is also a patient of the same general practitioner:

“Oh yes the beloved family they can cause untold problems. I will share with you that I have had a couple of patients who refused to see me because I wouldn’t do what they wanted me to do for a member of their family” (Kevin).

The tone of the statement suggests Kevin feels all families are trouble and burdensome. He appears to feels proud of the fact that he has lost some patients and emerged as the victor from a problematic battle. When later asked how it had made him feel to know a patient did not wish to see him, he said he felt relieved that he no longer had to deal with that particular problem. Kevin felt it was one less hassle.
All GPs agreed that taking actions to please the family is often not in the best clinical interest of the patient. When family wishes are not granted, the family often forms a negative opinion of the doctor. The opinion is based on their experience of the doctor and is used to judge clinical competence. This then acts as a catalyst for families to refuse to see a particular GP for their own health concerns. These situations may affect the professional reputation of the GP; I explore professional reputations further in section 4.4.1. All the GPs agreed that when families had a good healthcare experience and outcome they were likely to recommend the GP using their own experiences to support such recommendations. The following extract is a good example to demonstrate such points:

“I've had some real problems in the past. I've had comments such as, I'm sure if it was your father you'd soon do something. It's often hard trying to get past these kinds of barriers. It's not the best experience because ultimately the family uses it as a measure of your competence and ability” (Steve).

The extract demonstrates how some patients can almost turn a professional communication into a personal attack. Steve recognises the potential risks to his reputation if he does not manage families’ expectations. When I later asked how the experiences made him feel, Steve replied, frustrated and powerless because he knew that word of mouth can be damaging but it was out of his control. When I asked why he felt powerless, Steve said sometimes barriers could be not broken down. He suggested that on other occasions patients eventually understand the rationale for clinical decisions. In other instances he suggested patients were not interested in listening to what you had to say and were instead busy forming their opinion of you. Likewise, the following is another typical example that demonstrates feelings of powerlessness. The response further demonstrates how such barriers cause feelings of frustration for both parties:

“In those tricky family situations I sometimes feel that I can't do my job, judgments are made on what a family perceives to be the right course of action and you know that if you don't do it they'll see another doctor until they get what they want” (Josh).
Several GPs said that managing family expectations is a real pressure that is not always recognised outside of general practice. The following is another typical response that highlights how managing family pressures is a cause of frustration:

“People don’t appreciate the pressure from family expectations. Naturally families want the best for their loved ones. I understand that but they can’t see the bigger picture. If you don’t do something, namely prescribe an antibiotic you often get described as poor GP. Sometimes you have to be tough skinned because it can get to you when people make an assumption based on very little” (George).

The response suggests that George’s feelings of vulnerability are possibly due to unfounded assumptions made by a patient’s family. To manage this George has learnt to desensitise himself so he is not affected by such behaviour.

Several GPs admitted that at times they use prescribing as a means to end the consultation. GPs believed family demand created extra pressure for them. The following response demonstrates how GPs often feel forced into a situation that results in an outcome that is not necessarily in the best interest of the patient:

“Yes I’ve prescribed to get someone out of the surgery. I think we’ve all done that. I remember this particularly awful woman who wanted an antibiotic for her father’s supposed chest infection. I gave her the prescription to get her out. I felt pushed into that situation and I felt sorry for the patient” (Paul).

Paul feels pressured into taking an action that makes him feel uncomfortable. When further asked how these experiences made him feel he replied that he felt coerced into prescribing. He felt annoyed with himself for giving into such pressure, believing he had probably not acted in the best interest of the patient. The GPs agreed that antibiotics have a valued place in medicine. However, the following extract is a good example to demonstrate that antibiotics are not the cure all as perceived by many patients and family members:

"I had a situation not too long ago actually. A woman came in with her daughter and told me the daughter was unwell, was feeling rotten and needed a course of antibiotics to pick her up. The daughter sat there and didn't speak. When I began to talk to the daughter the Mother butted in, she said I’ve told you the
The extract highlights a high level of misunderstanding by the patient’s mother. Paul explained his feelings of sadness were in relation to not only the daughter but also the mother’s false beliefs of the power of antibiotic therapy. He believed situations such as these were uncommon. He said he had reflected on the consultation and had thought that maybe the mother had actually been seeking antidepressants for her daughter but had instead wrongly requested antibiotics.

4.3.3 Managing the Pharmaceutical industry

All GPs talked of regular communications from the pharmaceutical industry and all believed this did not influence their prescribing choices. Several of the GPs said they felt pressured by time. GPs claimed they did not often speak with or meet representatives from the pharmaceutical industry and believed they were not influenced by them. The following response reflects these points:

“No not really. I don’t have time these days. They were much more influential years ago, they still come into the practice but with the drug formularies and national drivers and guidance such as NICE guidance, the reps don’t really come into the equation; well not for me anyhow. I just don’t have the time to meet with them or even talk to them really” (Steve).

Steve implies that times have changed and that time pressures and prescribing guidance are two elements that reduce the need to see drug representatives. Some GPs suggested there is no longer a useful role for the pharmaceutical representatives in general practice. The following extract is an example of how time constraints affect the GPs' ability to see the representatives:

“No don’t get time to see the reps these days. They tend to leave literature at reception and a card probably in the hope you’ll call them. I never do, I do read the literature, well I try to” (James).
There was recognition that for some GPs the pharmaceutical representatives are a valid source of information particularly in relation to new drugs, as demonstrated in the following typical response:

“If there’s a new drug on the market, then they come into their own. You can’t get that in-depth knowledge of new drugs from study sheets and papers, as you can when you meet with the rep” (Kevin).

Several GPs recognised the need to develop their skills of critically appraising research evidence and the claims from the pharmaceutical industry that may be somewhat biased towards their own product. The following extract is typical response that demonstrates this point further:

“I was influenced by the hierarchy when I was a trainee GP. Now I’ve been at this for a considerable time it is more and more difficult to influence me without evidence. When I do see the occasional rep, I will only come onboard if the evidence for the drug is strong. When they present their papers that have positive outcomes, I’m interested. After all I want to get better outcomes for my patients and one way of doing that is prescribing more effectively” (Geoff).

Geoff does not appear to recognise any potential bias related to the research evidence and believes the influence is evidence based. Geoff does not acknowledge the limitations of only referring to research papers by the drug company themselves and he fails to recognise the need for independent scrutiny. Interestingly, his first comment suggests that influences from his trainee days were not necessarily evidence based. The influences may possibly have come from more habitual or ritualistic practice.

Several of the GPs described how they would not prescribe a new drug without clinical evidence. They were concerned that at some point, problems such as unknown side effects might emerge; therefore, they took a more cautious approach. The following typical response validates this claim:

“It’s easy to jump on the bandwagon of new drugs, and then you find that they’re not as safe and effective as first thought. They might be doing their job
but what wasn’t known is a list of unwanted problems such as the side effects outweighing the benefit of the drug” (Josh).

Josh clearly feels apprehensive about prescribing new drugs, preferring instead to wait until there is further information concerning the possible risks and side effects that may outweigh the benefits.

**Summary**

GPs often felt stressed and frustrated trying to manage the expectations of patients and their families. GPs believed that patients and families often formed opinions of them based on their experiences. GPs felt powerless to influence such opinions. It seems that these GPs do not feel that the pharmaceutical industry directly influences general practice prescribing patterns.

**4.4 Theme 4 - Managing Reputation**

The focus of this theme is on managing both professional reputation and the reputation of the practice. I also explore corporate and collegial responsibilities.

**4.4.1 My Professional Reputation**

Reputation was important to all the GPs who expressed concerns at how easily reputational damage could ruin an otherwise unblemished career. GPs felt this was important given the emergence of different patient and public forums and Internet websites that ask for patient feedback. The GPs expressed pride in their practice and all were keen to share their experiences of good practice. All of the GPs believed they had never been the cause of a patient complaint. They believed acting professionally accepting both their responsibilities and accountabilities were important factors. The following extract is a typical GP response:

“I'm not aware that a patient has ever complained about my practice. I take full responsibility for my actions. At the end of the day my name is at the bottom of
the prescription along with my signature that makes me professionally accountable. I have to be happy with my decisions, the buck stops with me. It’s my reputation that’s at risk if I don’t,” (Peter).

The inference to feeling happy with one’s own decisions is in contrast to earlier statements where some GPs shared their experience of patient and family pressure to prescribe against their clinical judgment.

Some GPs referred to instances where reputational damage had resulted from misunderstandings either by patients or by other health professionals. The following extract is a good example to highlight how reputational damage can occur from such misunderstandings:

“I remember being observed once a few years. I was criticised for my lack of communication with the patient. Apparently I should have spoken my thoughts out loud. I remember I was thinking all the time about what I could do for the patient but because I didn’t say it aloud, I appeared uncaring. The patient didn’t report it but the observer did. I learnt from that; no one wants to have a reputation for being uncaring. Of course GPs care or we wouldn’t be doing this job” (James).

The decision making process is often internalised rather than spoken aloud. The extract demonstrates that if a practitioner does not speak their thoughts aloud, they may not be inclusive and therefore perceived to be uncaring. This experience affected James because he did not appreciate that to be seen as caring, he needed to articulate his thought process.

Professional credibility was a concern for all GPs; all of them felt that it could seriously affect their future practice. GPs believed a good reputation was a marker of success. GPs perceived that patients viewed a doctor with an unblemished reputation as trustworthy and the following typical response supports this notion:

“My reputation is what keeps my name above the door and keeps patients coming through it. I’m a credible practitioner; I don’t want to lose that” (Steve).
The GPs felt that patients and potential patients quickly learn who in their opinion is a good or bad doctor. GPs believed that potential patients steer clear of those doctors deemed not as good as others. The following is a typical response that demonstrates the GPs frustration that they are not always given a fair chance:

“I’ve heard it for myself. Patients say “oh I’m not seeing him or her.” That gets overheard and it’s like Chinese whispers. Patients refuse to see a particular GP based on what they’ve heard or they think they’ve heard, though they’ve personally had no experience of that doctor” (George). George feels frustrated that patients base their refusal to see some GPs on nothing more than anecdotes, and hearsay. The following is a further example to demonstrate how such judgments caused feelings of inferiority in relation to colleagues and affected professional confidence:

“You get it wrong and patients don’t want to see you. Word of mouth is powerful. Patients hear that a GP is rubbish; the doctor got it wrong for me, that type of thing. They don’t want an appointment with you; you lose credibility. I think you’d feel inferior to your colleagues, and it would certainly knock your confidence,” (Paul).

When asked to clarify what he meant by wrong, Paul said it could relate to almost anything, from a prescribing issue to a late referral. Sometimes he said it is not even clinically wrong, rather judged to be wrong by the patient.

GPs believed that closely linked to reputation was credibility. A GP with a bad reputation could not be seen as clinically credible. The GPs agreed that when a professional reputation was damaged it was difficult if not impossible to rebuild. The following response reflects these points:

“Once you’ve lost your reputation you’ve lost your credibility. No amount of hard work will get it back unless you up and move elsewhere; mud sticks. I’m not really interested in what people think of me as a person. As a GP I want my patients to believe in me” (Peter).

The following is a further example of how a small error could make a big difference, and could result in a medical career being over:
“You only have to make one small human error and you could be ruined in the medical world. Unfortunately, patients never forget that you were the one who got it wrong. It’s satisfying when patients ask specifically to see you; you know that you are getting it right, that you have a reputation for being a good GP” (Michael).

Michael feels satisfied knowing that patients wanted to see him. He believes this is a reflection of a credible clinician with a good reputation. Michael later explained that knowing he had a good reputation made him feel good about himself as a doctor.

4.4.2 Managing the Reputation of the Practice

All GPs recognised the potential for reputational damage to the practice. The GPs suggested that a poor reputation would affect the overall reputation of the practice. Several GPs spoke of reputational damage caused by a name and shame approach. The GPs felt adopting this approach was both childish and humiliating, as this next typical response suggests:

“One GP gets it wrong, and the practice gets a bad name. We get measured against prescribing audits; we can be seen as outliers if we prescribe outside of policy. The individuals get a bad name; the practice gets a bad name. We end up like children on the so-called naughty step, held up as a bad example to colleagues in your locality. That’s humiliating” (Paul).

While the statement may appear to be flippant, the reference to humiliation may reflect the embarrassment Paul feels in finding himself in such a situation in front of colleagues. While being held to account in this way may promote feelings of degradation particularly in front of colleagues, this may be the desired effect in order to improve specific performance related outcomes. On a similar note, another example suggests managing one’s own reputation to safeguard that of the practice is yet another cause of stress for some GPs:

“You build up your practice and then something happens and you’re finished. It not only affects you as an individual but the reputation of the practice is damaged and that affects other partners. That’s what makes it all so stressful” (John).
The following extract is representative of many GPs who felt good practice was enough to safeguard not only one’s own professional reputation but also that of the practice:

“We are being held to account more and more. Some GPs don’t like that. My philosophy is if your practice is sound then there really isn’t much to be concerned about. I welcome it personally; I don’t worry about my reputation or that of the practice” (Peter).

The statement suggests that accountability causes feelings of unease for some GPs. However, Peter feels confident that the standard of his practice does not give cause for concern. All GPs spoke of their corporate and collegial responsibilities and described how the experience feels. The following extract is a typical response that highlights how professional accountability is a burden, particularly evident when other professional pressures are great:

“It’s hard sometimes; it all sits on your shoulders. Sometimes it does feel like a monkey on your back, we do it day in and day out but if you stopped and thought about it, the accountability for patients’ lives then you could easily become anxious and stressed. The pressure is great, you don’t think about it every day, but through particularly stressful periods an awareness of your accountability is always there” (Steve).

The phrases Steve uses, *everything sitting on his shoulders and a monkey on his back*, suggest he feels burdened and pressured by the responsibility and accountability of general practice. He feels he must be ever vigilant particularly in times of increased stress.

**Summary**

GPs felt their reputation could be damaged easily, making it difficult to restore one’s good name. The GPs acknowledged their corporate and collegial responsibilities and they believed their professional reputation affected the overall reputation of the practice. GPs wanted to have a good reputation and be recognised as credible clinicians. Some GPs feel burdened by their professional accountability irrespective of the length of time they had been in general practice.
4.5 Summary of Chapter

In this chapter, the findings have shown that the experience of prescribing is complex and multi-faceted. The GPs shared their experience of prescribing which emerged as a complex process. GPs sometimes based their clinical decisions on factors other than clinical assessment, such as intuitive feelings and habitual practice. A ten-minute consultation was often seen as restrictive to decision making. While some GPs try to involve the patient in the clinical decision making process it was evident from others that some patients do not wish to have such involvement. These GPs practiced in a hierarchical way, believing that patients had no role to play in the decision making process. Managing the risks and benefits of prescribing was a big consideration for all the GPs. A significant finding was that none of the GPs recognised Clostridium difficile as a real or potential risk even in those patients known to be a high risk.

GPs believed prescribing to be a powerful tool, which at times could be used to their advantage. GPs recognised clinical knowledge as one of the most important aspects for diagnosis and subsequent prescribing. All GPs spoke of the need to utilise their skills and competencies to deal with the many pressures associated with prescribing practice. Many GPs deliberated over whether or not to prescribe and this anxiety was exacerbated by diagnostic uncertainty and the risk that a serious condition could be missed. Diagnostic uncertainty was a cause of stress and anxiety for GPs.

Managing patient expectations and the delicate relationships with patients and their families was yet another cause of concern. There were general feelings that while some GPs were happy to negotiate with the patient, others felt this approach was humiliating and demeaning. Some GPs believed patients should adhere to the
‘expert knows best’ principle. Many stated that when they felt pushed by patient or family pressure they would prescribe. Managing family expectations was often seen as a further cause of stress with families placing unrealistic demands on GPs. Family relationships could affect their professional reputation. Professional accountability was seen as a burden by some GPs but this was just one of the many burdens GPs believed they faced in general practice. GPs suggested the pharmaceutical industry do not directly influencing prescribing decisions. GPs suggested they were guided by national drivers such as NICE guidance and regional and local prescribing policies.

All GPs were concerned with maintaining a good professional reputation. GPs suggested negative feedback from patients and their families can adversely affect their reputation. They recognised their corporate and collegial responsibilities and felt concerned that a damaged reputation could affect their colleagues and the reputation of the practice.

Finally, what was evident from the findings is that this group of confident and competent professionals all acknowledged that at times they not only felt stressed, frustrated, burdened, and anxious, but also vulnerable and powerless.

I will discuss these findings in chapter 5 in the light of existing literature.
Chapter 5
Discussion

Introduction

From the presentation of the findings from the study outlined earlier, key themes emerged and these will be discussed under the following four headings:

- The Experience of Clinical Decision Making
- The Experience of the Clinical Consultation
- Influences on Decisions
- Feeling Clinically Credible

5.0 The Experience of Clinical Decision Making

This section discusses the GPs’ experiences of clinical decision making; the role of the patient in the decision making process and the GP/patient relationship in the light of both challenges to power and entrenched attitudes to retaining power by the GPs. One of the strong features of the findings is that these GPs’ experiences of clinical decision making in prescribing were shaped by emotional responses within the GP/patient consultation. In chapter two, I argued that much of the literature on decision making was not applicable to my study because it does not focus on the lived experience. I introduced intuition and intuitive feelings in chapter 1 because they relate to clinical experience and emotions (section 1.3.3) and I will further discuss these aspects of clinical decision making and prescribing in this chapter.

5.0.1 The Intuitive Clinical Decision

A typical clinical consultation starts with the patient presenting their problem to the GP who then responds to stimuli and cues from the patient. The GPs described that the consultation is often brought to a close with the GP issuing a prescription. While on the surface the process of the consultation appears logical and straightforward,
these findings suggest a complex dynamic between GP and the patient.

The process of decision making has been widely studied and many theoretical frameworks exist (Bradley 1993, Carthy et al. 2000, Stolper et al. 2009, Stolper et al. 2010). The literature suggests that GPs often learn how to make clinical decisions in an amorphous or unstructured way (Essex and Healy 1994, Hardy and Smith 2008). These findings show that consultations put significant pressure on these GPs and in response, they used a variety of clinical decision making strategies. GPs’ decisions were often habitual, contextual, and not necessarily based on clinical foundations. This finding is in keeping with other studies where it is suggested that over 40% of GP decision making is based entirely on habit (Denig and Haaijer-Ruskamp 1992, Hardy and Smith 2008). These GPs’ prescribing decisions were not shaped by a framework and did not follow a rigid systematic process. These findings add to the body of knowledge of decision making.

While something is known of the non-medical and non-pharmacological influences that affect prescribing decision (Bradley 1991, 1992, 1993, Essex and Healy 1994, Denig et al. 2002), a real understanding of how such influences affect prescribing decisions is lacking. This study contributes to a deeper understanding of the emotional components of GP decision making rather than just intuition, which I did not find within the literature.

The first example from my data of informed intuitive decision making, is the rapid actions these GPs often used to manage their busy surgeries. Immediate rapid action decision making was aligned to their intuitive feelings, clinical experience, and patient cues, which prompted recognition of the symptoms and ultimately led to a clinical decision (chapter 4, section 4.1.1). This approach is recognised as being commonly
used in general practice (Essex and Healy 1994) and is a typical intuitive response to decision making (Denig and Haaijer-Ruskamp 1992, cited in Bradley 1993, p.10). Intuitive feelings, as a phenomenon, are complex and not yet fully understood. There is no consensus as to their accuracy or true value in medicine (Dreyfus and Dreyfus 1986, Croskerry and Norman 2008, Stolper et al. 2010, Woolley and Kostopoulou 2013).

In this study, intuitive feelings linked to the GPs’ professional expertise, with intuitive judgment dependent on how experienced the GP was in clinical decision making. For example, an experienced GP will rely more on intuitive feelings because their thinking has progressed from analytical to intuitive. The GPs in my study often intuitively knew what to do without applying analytical rules. In contrast, a newly qualified or less experienced GP will use a more reasoned analytical approach because they lack the clinical expertise and experience that triggers the unconscious intuitive response (Dreyfus and Dreyfus 1986, Dreyfus 2005, Croskerry and Norman 2008). The key components of analytical and intuitive decision making are highlighted in figure 7. Much thinking goes on between the two points of analytical and intuitive cognition (Hammond 1980). Clinical expertise develops with experience and the experienced GPs in my study made an immediate intuitive response to clinical situations (chapter 4, section 4.1.1). The literature supports this finding; although it was not clear either from this study or from the literature how many years of general practice experience is necessary to effectively develop intuitive feelings and be classified as an expert GP (Dreyfus and Dreyfus 1986, Dreyfus 2005, Stolper et al. 2009). The number of years the GPs in this study have been in general practice is shown in chapter 3, figure 3.
Intuitive feelings act as a diagnostic tool that many of these GPs learned to rely on. Intuitive decision making is an emotional process and emotions in the consultations were strongly felt by these GPs (Hammond 1980, Dreyfus 2005, Woolley and Kostopoulou 2013). For example, symptomatic cues from their patients triggered an intuitive response from these GPs based on whether the instinctive feeling was good or bad. This finding is important because it suggests that the unconscious intuitive interpretation of the patient information triggered an emotional response, which these GPs felt but could not articulate until asked in interview. The body sensations associated with good or bad feelings demonstrate how triggered emotions shape intuition. Emotions are, therefore, key aspects of intuition as a cognitive process. This concept is supported by Stolper et al. (2010), who suggest that good feelings give a sense of reassurance with no cause for immediate concern, because despite not having a diagnosis, GPs feel confident that nothing serious is wrong. In contrast, bad feelings give a sense of alarm, which cause concern and trigger an immediate need to initiate treatment (shown in figure 8). Intuitive feelings may trigger diagnostic reasoning but in situations where there was diagnostic uncertainty, the GPs in this
study took action. This is another important finding because it demonstrates that strong intuitive feelings caused these GPs to ignore rational analytical clinical reasoning. This finding is similar to those of Andre et al. (2012), who also found that GPs ignored rational clinical reasoning when they intuitively felt an urgent need to act promptly. In considering this need to act, Balint (1964) argues that sensing alarm is the point where these GPs needed to slow down, stop, and analytically reflect on their emotional response.

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**Figure 8**

In this study, the stimuli from the patient information coupled with the knowledge and experience of the GP prompted their intuitive reactions. The GPs did not make a conscious decision to use intuitive feelings because the signs and symptoms as told by the patient triggered this automatic subconscious process. Once started, intuition became part of their overall diagnostic process. This finding is consistent with two studies undertaken by Stolper et al. (2009, 2010), who suggest that feelings are key drivers in clinical diagnosis. Often the GPs in my study instinctively linked the patient cues to an illness or disease process, which subsequently triggered the treatment plan. Stolper et al. (2010) refers to this as diagnostic feeling, while Balint (1964) suggests it is active listening. By being acutely aware of patient cues, GPs can gain a greater understanding of the problem from the patients view. Managing diagnostic uncertainty evoked feelings of unease and anxiety in these GPs because they instinctively knew something was wrong but were unable to pinpoint
exactly what it was or what action to take. To manage this uncertainty they tried to find objective reasoning to support their instinctive feelings. This was also a finding in studies by Stolper et al. (2009, 2010) and this is discussed further in section 5.2.4. The GPs in this study used their intuitive feelings and knowledge, which was built on experience that was not spoken but resulted from information and implicit learning. This is in keeping with the work of Hardy and Smith (2008) who suggest that intuitive feelings or hunches are key tools used in the clinical decision making process.

The findings from this study suggest that intuitive feelings play a substantial part in diagnosing and prescribing decisions in general practice. Sacket (1996) recognised the value of tacit knowledge and intuition and questioned whether evidence based medicine alone always provides the answers. Furthermore, Sacket argues that while evidence based medicine may inform decisions, it cannot replace clinical expertise; therefore GPs should combine their clinical expertise with evidence based medicine in order to deliver safe, effective care. GPs can use their clinical expertise to determine if the available clinical evidence is applicable to their clinical decision but ultimately a combination of all these factors may support the final clinical decision. Other literature also supports this notion, suggesting an eclectic approach to decision making is widely used within general practice (Pendleton et al. 1984, Neighbour 1987). The GPs I interviewed used their unique experience, knowledge, and feelings to drive the process and outcome of their decisions and this approach is more effective than evidence-based medicine alone (Neighbour 1987).

Making a rapid immediate decision was more comfortable for the GPs in this study because they felt they had responded to what the patient wanted. This rapid decision making suggests the GPs in this study were outcome driven rather than process driven. The GPs did not see that the process of decision making would ultimately
drive their decision outcome possibly for the better as they tended to see process as constrained by time pressures. However, it may be more complex than this as Balint (1964) suggests that GPs are likely to feel more comfortable because they avoid thinking about the decision process; it is not time per se which constrains them from opening up the process but the fear of what allowing the process to develop might result in. Adopting a more analytical approach was not always the consultation method of choice, possibly because it is a far more time consuming model of practice (Balint 1964). The GPs in this study used inductive recognition, which was both experiential, and experience driven. This approach is not without risk because there may be over confidence in the intuitive decision (Croskerry and Norman 2008). Stolper et al. (2009) suggest that only experienced GPs have the self-confidence to rely on their intuitive feelings in clinical decision making. The apparent over confidence of some GPs in this study may have been linked to their experience and implicit knowledge but this was not confirmed in my data. Croskerry and Norman (2008) would suggest that in medicine, a lack of confidence and uncertainty is considered a weakness. Therefore, clinicians may exude an overconfidence to mask the uncertainty they really feel but again, this was not confirmed in my data.

Intuition is difficult to support with evidence and does not conform to the concept of medicine and medical science; therefore, it is often disregarded. There has not been sufficient research undertaken to either credit or discredit the reliability or use of intuition in clinical decision making (Dreyfus and Dreyfus 1986, Hardy and Smith 2008, Stolper et al. 2010, Woolley and Kostopoulou 2013), which suggests that further research is needed, (this is considered in chapter 6, section 6.3).

To improve the quality and accuracy of GPs’ decision making, many computerised programmes exist (Denig et.al. 2002). However, these GPs did not always welcome
such systems, possibly because they relied on tacit knowledge and intuition rather than evidence based medicine. In this study, some GPs felt that decision making was being taken away from them, which threatened their professional power. Misconceptions about the purpose of the system highlighted that some of these GPs were concerned that they would be held accountable for decisions made by the computer system. GPs did not recognise the system as a means to support their own clinical decision making (chapter 4 section 4.1.1). This is in keeping with the work of Denig and Haaijer-Ruskamp (1992), who suggest that computerised systems may not be widely used because they do not respect GP autonomy. However, Denig and Haaijer-Ruskamp also suggest that when such systems are used, GPs find them invaluable because they help to reduce the risk of decision errors (Denig and Haaijer-Ruskamp 1992). Denig and Haaijer-Ruskamp's work is in contrast to the findings of this study.

Clinical decision making is emotive, especially when patient's signs and symptoms do not match directly to any known disease pattern. When this happened, the GPs in this study felt anxious and uneasy. Dreyfus et al. (2005) also found that diagnostic uncertainty acted as a stressor in clinical decision making, because GPs do not have sophisticated diagnostics to hand or rapid access to diagnostic results, which causes their stress (chapter 4, section 4.2.4). In a general consultation, these GPs listened to their patients to understand the issue, which can be time consuming, as some patients tell long stories before getting to the point and may not even get to the point at all. Patients often presented information to these GPs but did not always articulate the real problem or reason for their consultation. Balint (1964) refers to this behaviour as the entry ticket. Given time, patients move onto the real issue and reveal what they really want. Balint (1964) terms such behaviour as the hidden agenda.
GPs have to listen while keeping control of the situation. This is a critical point in the consultation because the GP not only assesses whether the patient has said enough but also whether they, as the prescriber have heard enough of the patient’s cues to make a safe and effective clinical decision. This is also the point in the consultation where the GPs in this study felt most anxious, because getting the diagnosis right and treating the condition was their primary aim, although this was seldom straightforward. In moments of anxiety or uncertainty, the GPs acted and in most cases prescribed, (figure 8, chapter 5). In contrast, Balint (1964) proposes that GPs should stop and think, because in moments of anxiety and uncertainly, it is better to allow for thinking time to digest and reflect on the consultation than taking any other action. Issuing a non-medical prescription that provides helpful information for the patient is one way for GPs to allow both patient and self to stop and think. Balint (1964) would argue that the GP should bring the patient back for a further consultation to really allow time to stop and think. However, my data does not suggest this resource was utilised.

The GPs interviewed often felt uneasy and uncomfortable when prescribing and this was particularly apparent when considering contraindications and dosages. A mental risk benefit analysis was often used by these GPs but the worry of possible litigation, should something go wrong, was ever present (chapter 4, section 4.1.3). These GPs felt anxious, particularly in relation to possible side effects of drugs and drug interactions. The literature reflects this anxiety and suggests that side effects, serious adverse reactions, and contra-indications are the biggest prescribing concerns for doctors (National Prescribing Centre 2000). While findings from some other studies concur with my findings and suggest prescribing as a leading cause of stress for GPs (Bradley 1993, Miller et al 1999), this was not the finding of Kumar et al. (2003). Kumar et al. investigated why GPs prescribe antibiotics for a sore throat and found
that antibiotics were prescribed for two reasons, firstly they were a method of managing potential complications of the illness, and secondly, the quick option to prescribe reduced GPs’ stress associated with a busy practice. Kumar et al. acknowledge that these findings differ from other qualitative study findings of a similar topic by Bradley (1991, 1992, 1993) and Miller et al. (1999).

5.0.2 The Patient’s Role in Decision Making

Involving patients in their care is by no means a new concept and has been part of national policy over the last twenty years (Department of Health 2010). Recent policy documents give patients a bigger say and a greater role in decision making (Department of Health 2012). However, it appears that the national initiative ‘no decision about me without me’ did not always influence these GPs in their everyday practice. In this study, decision making was found to be a role mainly exclusive to the GP; furthermore, these GPs believed that their patients concurred with this concept (chapter 4, section 4.1.2). However, the findings also demonstrate that at times patients challenge doctors (chapter 4, section 4.3.1). The GPs in this study did not always give patients a choice or ask them what they wanted because they believed patients lacked the clinical skills and knowledge to make such decisions. While many patients would lack clinical knowledge, the GPs interviewed did not acknowledge that it was their role to give information to support patients in making a more informed choice. This is in contrast to the literature that suggests a fundamental element of the GP role is educating and informing patients to allow them a greater choice (Mead and Bower 2000).

The practice approach adopted by some of the GPs in this study does not fit with the concept of patient centeredness as proposed by Balint; neither does it forge the therapeutic alliance that Mead and Bower (2000) argue as being the fundamental basis of a good doctor-patient relationship. Some of these GPs felt that involving
patients in clinical decisions and asking patients what they wanted suggested that they, as doctors, lacked knowledge and insight. The concept of empowering patients was threatening to these GPs, possibly because they perceived knowledgeable patients as more powerful and this was evident in my data (chapter 4, section 4.1.2). There will always be patients who want to be involved and exercise their right to have a say in their clinical options (Bevington 1990). However, I suggest that this tension must be managed so that patients are not unfairly labelled as demanding or difficult.

Some patients may not want to be involved in the decision making process, preferring instead to abdicate responsibility to the GP. However, these GPs did not consider this notion, probably because they had already assumed such responsibility. This is consistent with the work of Pendleton (2003), who found that some patients adopted a model of dependency and delegated responsibility for their health decisions to others. This may be because such patients feel they have no control over their health and believe their health lays in the hands of powerful others such as the GP. This would indicate that patients continue to have an external locus of control (Rotter 1954). Sometimes, trying to involve patients in decision making backfired, for example in some cases patients changed doctors because they believed that the GP did not know what they were doing (chapter 4, section 4.1.2)

5.0.3 Feelings of Power

My data suggests that GPs feel that their role entitles them to power (chapter 4, section 4.2.1). My findings suggest that the concept of power is complex. The GPs interviewed described feeling powerful and at times feeling powerless. Professional medical knowledge, experience, and expertise are powerful tools, which the patient

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11 I did not interview patients; therefore, this study does not reflect patient experience, which I acknowledge and address in chapter 6, sections 6.2 and 6.3.
does not have (Balint 1964); thus power favours the GP. In contrast, these GPs described patients exerting their power to switch the power balance in their own favour; for example, some of these GPs felt powerless when they were no longer dominant. During the interviews, the GPs underplayed the powerful therapeutic effect they can have on their patients, yet their cathartic effect may be as powerful as some other medicines they prescribe. Some of their patients may re-attend for no other reason than the beneficial effect they feel from seeing the GP. Balint coined the term the drug doctor in 1986 to describe the GPs powerful therapeutic effect. As my findings suggest, GPs may purposefully play down this role so as not to encourage a culture, where the patient becomes dependent and somewhat addicted to the medicinal effects of the GP. Though the therapeutic effect of counsellors is well researched and understood (Jacobs 1999), I found no literature to suggest this concept had been widely studied in medicine. Therefore, I address this gap in the medical literature within chapter 6, section 6.3.

Having the legal power to prescribe is a position earned by a select group of professionals. Prescribing gives the GP the upper hand in the clinical consultation setting and some GPs in this study felt superior because they ultimately determined if the patient received a prescribed drug. Prescribing powers could be used to the GPs’ advantage, particularly when faced with perceived unpleasant or difficult patients. While patients who needed medications were never denied, my data show that these GPs sometimes used prescribing as a means to show professional authority, particularly when their patients tried to tell them what to do (Bradley 1993, Stevenson 1999). My data suggest that occasionally the GPs in this study felt a sense of satisfaction when they refused a patient’s request for specific treatments or medicines, most notably when the patient was seen as challenging (chapter 4, section 4.2.1). This finding is consistent with the literature, which implies that the GP
will always have the greatest power when negotiating and when managing patient demand, even though they may not always feel the most powerful (Bradley 1993, Roberts 2004).

Persuading patients that they do not need a prescription or persuading those that are averse to taking prescribed medicines that they need to follow a medication regime is frustrating because it can be difficult to change the minds of determined patients. For example, my data show that some GPs were concerned that patients who most needed drug therapy would not cash in their prescription or take a dispensed drug and this was a real cause of concern (chapter 4, section 4.1.3). This finding is similar to the other studies that have highlighted the difficult negotiations GPs often have with patients, particularly concerning antibiotic therapy, because many patients believe antibiotics are a cure all treatment (Bradley 1993, Miller et al 1999, Kumar et al. 2003). Negotiating with patients may make GPs feel uncomfortable as my data suggests but it does not undermine the power of the GPs because their expertise creates a power balance that tips in their favour (Roberts 2004). It is only when the patient exerts their power and disregards such expertise that the power balance switches to favour the patient. When this happened, the GPs in this study felt powerless (Roberts 2004). This highlights the complexity of GP power and the tensions that exist between feeling powerful and powerless. These emotions are not static as each patient consultation is unique. Consequently, the range of emotions felt by the GP will differ in accordance to how the patient presents him/herself and how the GP subsequently responds. Balint (1964) suggests that GPs should acknowledge their feelings and emotions because they may affect the consultation and benefit the patient.
Summary
The findings demonstrate that prescribing is complex and based on many factors both internal, such as intuitive feelings, professional and personal experience, and knowledge, and external, such as the patient’s signs and symptoms. The use of intuitive feelings in general practice is not yet fully understood and requires further exploration, which I address in chapter 6, section 6.3. Patients are not always involved in the clinical decision process, sometimes excluding themselves and sometimes being excluded by GPs. Medical prescribing is a powerful tool that often shifts the power balance of the doctor and patient relationship in favour of the GP. However, when patients exert their power, GPs often feel powerless.

5.1 The Experience of the Clinical Consultation
This section of the chapter will focus on the doctor and patient relationship and the feelings of empathy. The dilemma of whether to prescribe or not and GPs’ emotions when managing diagnostic uncertainty are discussed.

5.1.1 The Doctor Patient Relationship
Patient centeredness and shared decision making is by no means a new phenomenon. The national drive to put the patient at the heart of all decision making (Department of Health 2010) did not always translate into practice for the GPs in this study. For example, the data showed that decision making was often based on what was important to the GP, such as keeping to time rather than what was important to the patient (chapter 4, section 4.1.2). This does not reflect a patient centred approach, which focuses on the sharing of information and shared decision making (McWhinney 1985). Some of the GPs interviewed acted in the best interests of their patients but they did not always hear or listen to the patient’s voice. This reflects the GP as the dominant force within the GP and patient relationship. This may be a more
comfortable position for the GP because this approach fits with the more traditional biomedical framework (Mead and Bower 2000). An unspoken partnership agreement was in place whereby some of these GPs automatically took on the role of the advocate and sole decision maker. Furthermore, they expected patients to agree to decisions and adopt the standards as proposed by the GP. Such a fixed style of practice and rigid belief about how patients should behave is often termed the doctor’s *apostolic function* (Balint 1964). Such a unique way of managing patients meant that these GPs did not have to look at their own behaviours and they consequently developed a rigid style of practice (Balint 1964). Improved self-awareness of their beliefs and behaviours and reflection on action (Schön 1983) may have helped these GPs to understand why they found some patients difficult to manage and why some of their consultations left both themselves and the patient feeling dissatisfied.

When time allowed, some GPs in this study were more inclusive and worked with their patients to explore the various options available to them. Not only did this foster a working partnership, it resulted in a better experience of care for their patient. Shared decision making does not undermine the power of the GP but instead builds the doctor and patient relationship (Mead and Bower 2000). Some of the GPs interviewed also felt more satisfied with the quality and outcome of the consultation (chapter 4, section 4.1.2). This finding is consistent with the work of Balint (1964) who suggests collaborative working between a GP and their patient leads to better outcomes, particularly in terms of GP and patient satisfaction. A single long consultation can often provide new insight into patient problems and support an early resolution (Balint 1964). Though modern day practice does not always lend itself to such a model, general practice allows patients to be called back quickly and seen over a succession of consultations. The GPs in this study recognised that adopting
this approach was a way to build an emotional rapport and a trusting relationship with
the patient. As Balint (1964) suggests, GPs are in a unique position to develop a
mutual investment fund, founded on shared experiences and trust.

The GPs in this study described the relief they felt when perceived difficult and
demanding patients left the practice because they no longer had to manage the
complexities of a turbulent relationship or the associated problems (chapter 4,
section 4.3.2). This is in contrast to the work of Balint (1964), who theorises that GPs
may feel humiliated, guilty, and angry when patients leave them to take up with
another doctor. While Balint suggests that the act of leaving the practice reinforces to
the GP that s/he is not as good as they thought they were, this was not a finding in
my study. The GPs in this study were more concerned with managing their
professional reputation, (as discussed in section 5.4 of this chapter). Maintaining a
good patient relationship was important to the GPs in this study because they
recognised that a good relationship with the patient led to a more satisfactory and
empathetic consultation (Roberts 2004).

5.1.2 Feelings of Empathy

Empathy as a concept in general practice is complex and multifaceted. Patients
expect their GP to be caring and empathetic (Mercer and Reynolds 2002). Putting
oneself in the position of the patient is not always practical because GPs risk feeling
completely burdened by the heavy weight of patients' problems (Balint 1964). The
GPs in this study described a fine line between being empathetic and caring and
becoming too attached and emotionally involved. They feared they could lose their
objectivity and so felt they needed to remain somewhat detached. They described
feeling a tension between being detached and appearing cold and aloof, or becoming
attached and consequently appearing empathetic and understanding, (chapter 4,
sections 4.1.2 and 4.3.1). These findings are similar to those of Nettleton et al. (2008) who investigated the emotional aspects of medical work. Empathy is an essential component of compassionate practice but the tension between empathy and rationality needs to be carefully balanced. Ricoeur (2007) terms this just balance. Many models of empathy exist (Barrett- Lennard 1981, Morse et al. 1992, Reynolds 2000) but my findings represent the emotive element of empathy and the associated concerns of getting too involved. Morse et al. (1992) take a different perspective and propose clinical empathy as a professional interaction rather than a purely personal emotional experience. Morse et al. suggest it is not necessary to sense the patients’ suffering from an emotional perspective to demonstrate empathy. While this approach may eliminate the risk of attachment, the GPs I interviewed could not apply this in practice because often they felt an emotional connection and an emotional presence with the patient. This finding typically represents the concept of empathy (Halpern (2001), Burcher (2011). Understanding the feelings of the patient is the fundamental element of empathy. Personal first-hand experience of a problem helped these GPs to identify, understand, and then communicate such understanding to the patient; thus displaying empathy (Mercer et al. 2002).

It was evident from my data that clinical empathy remained patient focused (chapter 4, section 4.3.1). The GPs in this study had an automatic response to their patients’ cues, which is an important point because it implies that empathy is also an unconscious automatic response to patient need (Spiro 1992). These GPs used reflexivity as a strategy whereby their personal experience influenced their interpretation of the patient’s situation (Baarts et al. 2000). However, Garden (2009) argues that when GPs use their own experiences to demonstrate empathy, it can lead to them focusing on their own experience rather than the experience of the patient but this was not a finding of my study. However, GPs do need to be
conscious of the risk of counter transference, because if the focus switches from the patient’s problem to a past experience of the GP, strong emotions relating to the experience can be evoked which may reawaken unresolved issues for the GP (Davis 2009).

Feelings of empathy and forming patient attachments can be burdensome and can lead to burnout (Burcher 2011). The experience of the GPs interviewed highlights that connecting with patients often affected their ability to sleep when off duty (chapter 4, section 4.3.1). Some GPs feared that getting too close to the patient would result in being ineffective because they felt overwhelmed. It was not clear from my findings whether GPs allowed themselves a few moments to recover from an emotionally draining consultation before seeing another patient. This mode of *housekeeping* is a mechanism used to clear one’s mind of the issues raised from one consultation as a way of ensuring it does not negatively affect the next one (Neighbour 1987). Sometimes the GPs in this study felt the burden of patient responsibility was too much and outside their scope of knowledge. In such cases, they sought the expertise of specialist colleagues. This dilution of responsibility lightened the load for these GPs because they shared their burden of patient responsibility (Balint 1964).

### 5.1.3 To Prescribe or Not Prescribe

The GPs in this study felt that deciding whether or not to prescribe was a dilemma that often caused unease. While the patient’s problem and the best available evidence should drive the prescribing decision (Bradley 1993, Thornton 2006), the reality was not so simple. For example, the GPs in this study often felt obliged to act and do something for their patient. Quite frequently, the *something* translated into issuing a prescription regardless of whether clinically needed or not. The option to do
nothing was rarely chosen, even though at times, doing nothing may have been the right option and in the best interest of the patient. This may be because being unable to do anything is a frustrating experience for GPs (Balint 1964) (chapter 5, section 5.0.1). Such clinical practice was a typical response to perceived patient need and served three purposes. Firstly, these GPs believed it showed patient understanding and empathy; secondly, it was an action that was not time consuming, and thirdly, these GPs felt more comfortable when they acted in this way. Prescribing may be a quicker option but talking to the patient to find the root cause of their anxiety can be therapeutically beneficial (Balint 1964). Patients are often over anxious and share their concerns with their GP, expecting a clinical response in return. GPs feel they must give something back to the patient even if the undetermined something is not clinically rational (Balint 1964). Again, this highlights that these GPs focused on reaching an outcome rather than investigating and understanding the real clinical issue (section 5.1.2 of this chapter). Prescribing without clinical justification may cause two problems. Firstly, it falsely affirms to patients that they are sick; thus giving them a genuine reason to adopt the sick role (Herzlich 1973, Parsons 1975), and secondly, it can foster a dependency on the GP.

In this study, the GPs’ discomfort arose from deciding whether or not to prescribe, with antibiotic prescribing causing the most unease. This finding is reflected in a study by Bradley (1993), where it is suggested that despite being one of the most frequent prescribing decisions, it is one of the most uncomfortable (previously discussed in section 5.1.1). There are many influencing factors for such unease, including patient pressure and diagnostic uncertainty, particularly in children. GPs felt tension when assessing the risks and benefits of a medication and the potential that a prescribed drug could mask an undiagnosed condition, which added to the dilemma of whether or not to prescribe. Using a wait and see approach before
cashing in a prescription was a mechanism used to safeguard the GP and the patient should the symptoms worsen (discussed further in section 5.2.1). Previous studies have attempted to understand the influences on prescribing but they have not focused on the experience of whether or not to prescribe. This apparent gap in the literature may require further investigation to gain understanding.

5.1.4 Diagnostic Uncertainty

GPs are generalists and though some have specialist interests, they do not have the specialist knowledge of their hospital consultant colleagues (Bradley (1991), yet they frequently face complicated and vague problems that have no definitive answers. There are two things going on here. Firstly, as generalists, GPs are not well placed to diagnose specialist problems and secondly, GPs are faced with vague symptomatology, which can be difficult to diagnose. While they are trained to manage uncertainty, it still caused the GPs in the study to feel uneasy. This is because patients expect their GP to be able to tell them what is wrong, even though this is not always possible (Miller et al 1999). Diagnostic uncertainty is difficult to manage and therefore a cause of concern because these GPs instinctively felt that something was wrong with their patients, which evoked strong emotions. For example, the GPs in this study felt uneasy even though they had no clinical diagnostic evidence to support their feelings (discussed in section 5.1.1) and my data highlights this point (chapter 4, section 4.2.4). In such situations, these GPs were often uncertain about diagnosis, prognosis, and treatment options. While a diagnosis could not be determined, the GPs in this study instinctively felt the need to act and they often did, even though there was uncertainty as to what exactly they were reacting to. It is at this critical point where Balint (1964) would advise, ‘stop, do nothing, and think.’ However, the action taken by the GPs in this study is not unique because Katz (1984) also found that diagnostic uncertainty is the central driver for
overprescribing. In this study, prescribing gave the GPs reassurance, particularly when their instinctive feeling was bad, which caused them a sense of alarm. By prescribing, these GPs believed they had fulfilled their professional duty of care, been responsive to patient need, and safeguarded themselves should the patient’s condition worsen (section 5.1.2 of this chapter). This finding is in keeping with work by Kumar et al. 2003, who found that GPs manage clinical uncertainty by prescribing. The GPs interviewed believed that not responding equated to negligence and should the patients rapidly deteriorate, such non-action would be indefensible. This finding was not apparent in other studies.

In this study, diagnostic uncertainty evoked the emotion of anxiety, with varying levels of unease felt by these GPs according to the age, history, signs, and symptoms of the patient. The most vulnerable groups of patients, such as the elderly, with their complex co-morbidities, and young children were the biggest cause of concern for the GPs interviewed. The uncertainty of not knowing what they were dealing with meant these GPs were unable to predict what might happen in terms of both the disease progression and the associated treatment options. Prescribing in such situations reassured the patient and benefited the GPs, who felt more comfortable that they had acted rather than doing nothing. This finding is consistent with the work of Bradley (1991), who suggests uncertainty undoubtedly leads to prescribing. Balint (1964) suggests that doctors feel burdened by not knowing what is wrong with patients. They cannot tolerate not being able to help their patients and this drives their need to act and do something. Furthermore, Balint theorises that GPs understand that prescribing medication before making a diagnosis can mask both the symptoms and disease. While the GPs in this study could rationalise this, but they were unable to implement this concept because their subconscious need to
relieve their conscience led to them giving the patient something for reassurance and this was usually a prescription (Balint 1964).

**Summary**

The experience of the clinical consultation evokes many emotions in GPs such as uncertainty, stress, anxiety and satisfaction. These GPs did not always practice using a patient centred approach. However, when time allowed, most tried to be inclusive and involve the patient in clinical decisions. Managing the GP and patient dynamic can be challenging. GPs try to build a conscious emotional rapport with their patients in order to understand and empathise. Many GPs feel uneasy with building emotional attachments with their patients for fear of losing their objectivity. Making the clinical decision of whether to prescribe or not is often fraught with tension, particularly if the GP does not prescribe when patients want them to. This can sometimes have a negative effect on the GP and patient relationship. Managing vague symptoms are part of GP training. However, diagnostic uncertainty continues to cause GPs to feel uneasy and as a result, they often take action and issue a prescription. The experience of deciding whether to prescribe or not requires further investigation, which are considered in chapter 6, section 6.3.

**5.2 Influences on Prescribing Decisions**

This section of the chapter focuses on the external, non-medical, non-pharmacological influences on prescribing and the role of the patient and their family in prescribing decisions. I also discuss the constraints of time, the influence of policy, and the role of the pharmaceutical industry.
5.2.1 The influence of the Patient and their Family

The patient and their family were a dominant influence in prescribing decisions and managing this was both demanding and stressful (chapter 4, section 4.3.1). There is a conflict in the literature concerning the degree of influence patients exert. For example, Stevenson (1999) found that perceptions among GPs of patients’ demands and expectations were a key driver in the decision to prescribe. However, Miller et al. (1999) argue that while patient pressure is a stressor, it does not sway prescribing decisions. However, in this study, the GPs’ response to perceived wants and demands from the patient influenced them to issue a prescription (chapter 4, section 4.3.1); other factors also influenced GP prescribing as discussed within this chapter. Adopting the principles of active listening (section 5.1.1 of this chapter) may have enhanced the understanding of the patient expectation and identified that the GPs’ perception of what was wanted was not attuned to that of the patient (Balint et al. 1993). Other studies also highlight that the perceived patient expectation of receiving a prescription is often the basis for GP prescribing decisions (Webb and Lloyd 1994, Bradley 1993, Kumar et al. 2003).

My data suggest that patients and families perceived to be demanding or difficult often received a prescription because GPs found this option less stressful and less time consuming than negotiating and justifying that a prescription was not necessary. Issuing a prescription was a mechanism these GPs sometimes used to end a consultation. GPs employed this tactic when consultations were overly lengthy or emotionally difficult (chapter 4, section 4.3.1). The literature supports this finding and suggests that on occasions GPs do prescribe to terminate a difficult consultation (Bradley 1993).
Patients are now more informed and aware of health issues than ever before (Nettleton et al. 2008, Fischer and Ereaut 2012); with the use of the Internet and access to health initiatives in other countries, patients are more questioning and challenging (Nettleton et al. 2008). The GPs interviewed described how patients did not always understand why certain treatment options available in other countries were not available to them. GPs found offering explanations to the patients both time consuming and frustrating. This was also a finding for Fischer and Ereaut (2012). The GPs in this study often blamed the Internet and media for the unrealistic demands from patients and their families. This finding is not unique as Nettleton et al. (2008) also found that the Internet was partly responsible for an increase in patient expectations. Managing these expectations in the consultation is a challenge and requires careful management skills to ensure a good consultation outcome for both GP and patient.

The GPs interviewed felt frustrated when patients questioned or challenged them, because they felt that the patient did not recognise them as the expert who knows best. This may also be because the patient did not conform to an unknown set of values held by the GPs, though Balint (1964) would suggest that such frustration might be an anxiety reaction to the threat of patient challenge. The pressure of patients wanting a prescription influenced these GPs and although they felt uneasy, they issued the prescription as requested because they wanted to maintain the status quo. This is evident in the data (chapter 4, section 4.3.1). The literature supports this finding and suggests GPs feel discomfort when they succumb to patient pressure and prescribe to maintain the doctor and patient relationship (Bradley 1993, Webb and Lloyd 1994). This “patient collusion” is a typical response to perceived patient pressure (Balint 1964).
The GPs in this study used delayed prescribing as a tactic to give reassurance to patients and because it was a more emotionally comfortable option for them than doing nothing. A wait and see approach also allowed time for these GPs to reflect and explore possible explanations for patient symptoms. This strategy is widely used and familiar to most GPs; furthermore, it gives patients a choice and demonstrates patient centred consulting (Miller et al 1999). Practicing such an approach served two purposes for these GPs. Firstly, it shortened the consultation times, which reduced the risk of running a late surgery, and secondly, it may have prevented patients re-attending surgery when a condition failed to resolve without prescribed medication. This finding concurs with the literature and particularly the work of Kumar et al. (2003) who suggests wait and see is a useful method employed by GPs to prevent unnecessary patient re-attendance. Kumar et al. further suggest the wait and see approach also gives patients some responsibility for their own care. The wait and see concept is not new and possibly derived from Balint's 'wait and think' approach. Balint proposes that GPs do not act immediately but wait and allow themselves thinking time, (section 5.1.1 of this chapter). Bradley (1993), who suggests that GPs need time to consider treatment and prescribing options away from the pressures of clinical consultation, supports Balint's approach. Such practice was not evident in my data. So delayed prescribing was not implemented in these GPs' practice.

Some of these GPs believed such action implied they do not really know what they are doing (chapter 4, section 4.3.1). I did not find literature to support this finding, though Kumar et al. (2003) did find that a minority of GPs believed delayed prescribing adversely affected the relationship of trust between GPs and patients (Kumar et al. 2003). The GPs in this study described how their feelings of stress and frustration often related to the unrealistic demands of families that were not in the best interests of the patient. For example, trying to rationalise and negotiate with
families, intent on securing an antibiotic prescription was both time consuming and problematic for these GPs because families could become difficult and sometimes offensive. This finding is similar to those found by Nettleton et al. (2008), who investigated the emotional aspects of medical work and found that difficult patients caused feelings of resentment and anger among GPs. Balint’s (1964) theory of the consultation suggests that when patients provoke such feelings, the feelings should be acknowledged and used to benefit the patient. It was not evident in my study that the GPs had adopted Balint’s approach. While there are ongoing Balint groups, the number of Balint practicing GPs is small (http://balint.co.uk).

Belief that patients wanted a prescription appeared to be a dominant influence for these GPs to prescribe. This finding is similar to those of Virji and Britten (1991) and Stevenson (1999), who suggest that the perception often becomes the influence on the clinical decision. In my study, the GPs perception of both patient and family expectations was a key driver for their decision to prescribe. Managing the patient and family relationship is complex because the need, as perceived by the GP, may be at odds with the real expectation of the patient. However, reflecting the perceived need back to the patient may provide clarity and understanding for both GP and patient. This concept is the first stage of the theoretical framework of consultation (Stott and Davis 1979). The GP manages the presenting problems and fosters a mutual understanding with the patient by defining the reason for the consultation and determining the patient’s ideas and expectations, which is shaped by both the GP’s and patient’s emotions. This approach will enhance the emotional understanding and rapport between the GP and patient (Resnick 2012).

Negative relationships with patients can affect professional reputations and the GPs in this study felt anxious and powerless to control this. This was a particular concern
for these GPs when their decision was at odds with that of the patient or family’s wishes. For example, often when patients did not agree with the GP’s opinion, patients tried to negotiate or they changed GP (chapter 4, section 4.3.1). This finding echoes the early work of Balint (1964), where he suggests that patients accept the GP’s word, argue their point, or switch to a new GP, whom they believe is more attuned to their own needs and beliefs. These GPs believed that most patients expect a prescription, which is an important point because it exposes key misunderstandings in the GP and patient dynamic and highlights the fact that the expectations of the GP and patient are significantly different. A shared understanding of expectation is essential for a patient centred consultation (Neighbour 1987).

My data demonstrate that prescribing to close the consultation often sets a precedent and these GPs got caught in a vicious circle where patients expected a prescription every time they experienced similar signs and symptoms (chapter 4, section 4.2.3). For example, justifying to the patient why they may not prescribe, even though they had previously done so, was a difficult and uncomfortable experience for these GPs because if they refused to prescribe, they risked being challenged concerning their rationale for the original prescription. This finding is consistent with the literature (Bradley 1993, Miller et al. 1999, Kumar et al. 2003), which suggests that GPs will often prescribe where they have previously set a precedent, even if there is no clinical justification. There are several reasons for such action. Firstly, having set a standard, they feel pressured to prescribe, and secondly, they want to manage the expectation of the patient (Bradley 1993, Miller et al 1999, Kumar et al. 2003).

The GPs in this study found difficult patient consultations uncomfortable and they felt uneasy, particularly when the patients became confrontational. These GPs were concerned that losing a patient or family from their list in this way could adversely
affect their professional reputation (discussed in section 5.4 of this chapter). This coincides with the findings of Nettleton et al. (2008), who found that GPs felt confrontation and unfair criticism threatened their career. Such emotions were not consistent with all the GPs interviewed. For example, some GPs felt relief that they no longer had to deal with the challenges and hassle of difficult and sometimes unpleasant patients. Therefore, a good outcome was achieved when such patients left the practice. This finding was not echoed in the literature (chapter 4, section 4.3.2)

The GPs in this study believed patients knew how to play the healthcare system to get what they wanted and they felt powerless to control such game playing. For example, when GPs refused to prescribe antibiotics, patients often saw another GP partner until they got what they wanted (chapter 4, section 4.3.1). Patients can be persistent in trying to get what they want, whether they clinically need it or not. Other studies also found patients were persistent in securing their demands and often had a strategy to get their own way (Bradley 1993, Stevenson 1999).

5.2.2 The Influence of Time Pressures
Ten minutes for a consultation can be restrictive and result in a prescription, rather than focusing on the patient’s real problem (Kushner 1981). The GPs in this study repeatedly said that time pressures affected the quality of the consultation. With limited time, these GPs found it was often quicker to prescribe than to explore the underlying reasons for the patient consultation (chapter 4, section 4.1.1). This finding is not uncommon (Stevenson 1999, Hyde et al. 2005). Despite knowing how to conduct a consultation, time pressures and increasing patient caseloads were catalysts for these GPs to prescribe, even when there was no real clinical indication to do so. Undertaking a detailed clinical assessment takes time and skill and does
not fit comfortably with the ten minute, one problem only, modern consultation concept. The long consultation proposed by Balint (1964) does not only refer to one single consultation but a series of consultations that allow GPs time to explore and understand their patients’ problems. Adopting this practice can be a solution when time pressures affect the quality and outcome of the consultation (Balint 1964). For the GPs in this study, working with the ten-minute consultation rule encouraged a prescription because it was a quicker response than exploring other treatment options, which may take more time. This is in keeping with the literature that implies that time constraints were a dominant factor in not converting good intentions into practice (Carthy et al. 2000). This also supports the findings of Kumar et al. (2003) who found one of the reasons GPs prescribed for a sore throat was to manage their own stress associated with balancing time pressures in a busy practice (chapter 5, section 5.1).

When time permits, most of these GPs felt comfortable to spend time exploring options and discussing clinical decisions with their patient in detail and this resulted in greater mutual satisfaction in the quality and outcome of the consultation. The GPs interviewed described how time constraints were a key factor for not being able to keep clinically updated, though protected learning time was available for some (chapter 4, section 4.2.2). Time pressures coupled with an ever increasing and demanding workload are factors for GPs feeling overwhelmed, with some GPs facing burnout (Carthy et al. 2000, Burcher 2011).

5.2.3 The influence of Policy
The Departments of Health and Public Health continue to work together to optimise prescribing at a national level (2012). The GPs I interviewed described how working within the parameters of National guidance and regional and local policies was
restrictive and didactic and yet another constraint. This finding is not unique as Carthy et al. (2000) also found that GPs see national policies as political, interfering, and restrictive. The GPs in this study described emotions relating to stress and discomfort when having to justify prescribing decisions to their patients because patients may not be interested in NHS budgets or financial constraints (chapter 4, section 4.31). These GPs suggested that patients thought they hid behind policies and used them as an excuse for not giving patients what they needed. The GPs in this study felt irritated when directed to guidance that they found difficult to translate and implement in practice, In addition, being told what to prescribe was found to be tiresome and restrictive to clinical practice. This finding corresponds to that of Kumar et al. (2003), who showed that complying with policy was a cause of GP frustration because policy implementation did not always equal better patient outcomes.\textsuperscript{12}

5.2.4 The Influence of the Pharmaceutical Industry

While much of the literature suggests that the pharmaceutical industry has a direct influence on general practice prescribing (Bradley 1993, Carthy et al. 2000), the findings of this study suggest otherwise. It is complicated as some studies have found that physicians believe the pharmaceutical industry does not directly influence their prescribing decisions (Duerden 2011), while, other literature implies that the pharmaceutical industry is unlikely to continue with costly campaigns if they did not directly influence GPs in their treatment and prescribing choices (Bradley 1993). Despite regular communications from the pharmaceutical industry, the GPs in my study did not believe it influenced their prescribing choices. However, these GPs may have associated a direct influence with the historic practice of free GP dinners and

\textsuperscript{12} GPs are constantly under pressure to work according to protocol. Although not discussed here in any depth, these data suggest these GPs may have felt that their professional status was being challenged. This is an argument in the deprofessionalisation literature. McDonnell et al. (2009).
incentivised gifts from the drug representatives. Nowadays, such practice is no longer permitted and the GPs interviewed believed the influence no longer remained (chapter 4, section 4.3.3). However, these GPs did recognise the pharmaceutical representatives as a valid resource in relation to new drugs but the influence came from the associated drug research papers rather than drug representatives. New drugs influence prescribing behaviour but whether or not they are prescribed may be dependent on whether the GP is an innovator or a more cautious prescriber (Fischer and Ereaut 2012). It is not possible to monitor new medications in general practice in the same way it happens in acute settings and the balance of patient need versus safety and effectiveness has to be carefully considered (Fischer and Ereaut 2012).

The GPs in this study felt comfortable prescribing new medicines from a perceived reliable evidence base but at times they seemed to lack awareness of the potential bias of research that had not been independently undertaken or evaluated (chapter 4, section 4.3.3). This finding is not unique, as Bradley (1993) suggests most GPs lack critical appraisal skills and may be swayed by impressive results that have not been rigorously scrutinised. My findings suggest that the GPs interviewed may need to learn and use skills of critically appraising evidence to determine the quality of the research in relation to research findings. Carthy et al. (2000) suggest that once GPs become more astute at evaluating research, they may make more confident prescribing decisions. When prescribing new drugs, the definitive short and long-term side effects may not be known and this uncertainty was a cause of concern for some GPs in this study. This is in keeping with the literature, which suggests that apprehension associated with prescribing new drugs is commonly due to the uncertainty of side effects and risks (Bradley 1993). The GPs in this study described how peer support, particularly from individuals within their own practice, was a good resource to discuss new drugs. The findings of this study suggest that although the
GPs did not recognise a direct influence, they were influenced indirectly by the pharmaceutical industry; although this influence was downplayed in the interviews.

Summary

Many external nonmedical and non-pharmacological influences affect prescribing decisions. GPs often feel pressured by the influence of patients and their family. Trying to manage patient and family expectations can be both challenging and frustrating. Time constraints also cause GPs to feel stressed and in an attempt to effectively manage their time, GPs take action, which is, more often than not, in the form of a prescription. National and local policies are restrictive for some GPs because they believe policies do not always translate well in practice and this adds to their feelings of frustration. GPs feel they are not directly influenced by the pharmaceutical industry, as they no longer have the time to meet with the representatives. However, the industry remains an indirect influence in GP prescribing decisions.

5.3 Feeling Clinically Credible

This section of the chapter focuses on maintaining a good reputation and feeling clinically credible. I also discuss emotions relating to reputational damage.

5.3.1 A Good Reputation

The GPs in this study described how maintaining a good professional reputation was fundamental to clinically credible recognition. These GPs believed that patients want to see doctors with a good reputation because such GPs are more competent. A good professional reputation may be an indicator of success but reputations are fragile and easily damaged, particularly when a patient’s experience of care is poor. For example, the GPs in this study described how the doctor patient relationship was
crucial to maintaining a good reputation because patients can quickly form opinions based on their experience, in addition to what is known about the GP (chapter 4, section 4.4.1). However, sometimes the information can be flawed and unfounded. Patients and their families often refuse to see doctors that they believe are either not as good as others or that they perceive as incompetent. These GPs felt they were sometimes unfairly labelled incompetent simply because either their clinical opinion differed to that of the patient or they did not give in to patient pressure or demand.

Feelings of powerlessness and frustration were common in these GPs because they felt they could not control what patients said about them. When professional reputations are called into question, professional confidence may be undermined and this can negatively affect clinical practice as the GP then begins to doubt his own ability. Perceived unfair criticism evoked strong emotions in these GPs. For instance, they felt disappointed in themselves and offended because they tried to work in the best interest of their patients. It was not possible to determine if this finding is unique or in keeping with the literature because I was unable to source any literature that had researched professional reputation. I address this in chapter 6, section 6.3. However, Nettleton et al. (2008) studying medical emotions reported that unjustified criticisms cause feelings of vulnerability and upset among GPs. Formal complaints by patients can threaten the GPs’ career.

The GPs in this study were concerned that clinical credibility can also be lost with GP colleagues. For example, GP prescribing data was often held up as poor practice or benchmarked against that of other colleagues (chapter 4, section 4.4.2). Some of the GPs in this study felt humiliated and unfairly treated by such action.
Summary

Feeling clinically credible is important to GPs because they want recognition as credible professionals and they believe that maintaining a good reputation is essential to achieving this. Sometimes GPs feel powerless to control the external influences that may affect their reputation such as patient opinion, which causes frustration. I did not find literature that focused on maintaining doctors’ professional reputation, and I address this in chapter 6, section 6.3.

This study focused on GP prescribing, however there are implications for nurse prescribers, particularly those working within general practice that have taken on extended or specialist roles within primary care. Nurses are fully accountable for their prescribing decisions and, following consultation with their patients make prescribing choices. Some themes from this study such as to prescribe or not prescribe, time pressures and clinical reputation may be echoed by nurses however, the experience of nurse prescribing in general practice has not been investigated. I acknowledge this gap in chapter 6, section 6.3.2.
Chapter 6
Conclusions

Introduction

In the previous chapters, I introduced and presented the background, context and motivation for the study, in addition to outlining the research aim and research question. The literature scoping exercise was presented and the concept of hermeneutic interpretive phenomenology introduced. The research methods were outlined and the findings were presented and discussed in the light of the available literature. In this final chapter, I review the extent to which the chosen research methodology has met the aim of the study and answered the research question. The unique contribution of this study is presented and the study limitations are acknowledged before I propose the implications for practice, education and research. Finally the conclusions of the study are presented.

6.0 Answering the Research Question

This study was successful because my exploratory approach of interpretative hermeneutic phenomenology (described in chapter 3) supported me to explore, interpret, and understand the lived experience of antibiotic prescribing in the context of medical prescribing. The theoretical underpinnings of Hermeneutics align to interpretative phenomenological analysis and when used as a methodology, I was able to focus on the language the GPs used to describe their individual experience. This heightened my understanding of their emotional prescribing experience.

My sample size was small with ten male GPs recruited to the study. However, a small sample size allowed me, as a lone researcher, to immerse myself in the study (chapter 3, section 3.4.1). For example, I was able to explore the unique lived experiences of each GP because I personally conducted the face-to-face
unstructured interviews. By transcribing and manually analysing the data myself, (chapter 3, section 3.6), I felt confident that I had interpreted and understood the experiences the GPs had shared with me. However, I validated the transcripts with the GPs to confirm I had truthfully reflected their individual unique lived experience (chapter 4, section 4.0). Furthermore, by undertaking the research and moving through the research process, I saw hermeneutic phenomenology in action. Therefore, I believe my chosen methods and methodology were appropriate because I met the aim of my study and answered my research question, that being, what is the lived experience of antibiotic prescribing in the context of medical prescribing?

6.1 Original Contribution of this Study

The original contribution made by this study is threefold. Firstly, it adds to the body of knowledge, secondly, it contributes to the research methodology, and thirdly, it contributes to theory.

6.1.1 Contribution to the Body of Knowledge

The original contribution to the body of knowledge is that this study suggests that GPs use intuitive feelings to guide their prescribing decisions and GPs emotions are involved in clinical decision making. This study is unique because it is the first of its kind to focus on the lived experience and the emotions associated with clinical decision making in prescribing. My findings lend support to evidence from the studies by Hammond (1980), Balint (1964) and Stolper et al. (2009, 2010) who have also explored emotions and intuitive feelings. Other studies such as those by Bradley (1991), (1992), (1993) and Stolper et al. (2009), Stolper et al. (2010), have focused on the process of clinical decision making and the influences on prescribing decisions. Balint (1964) previously studied GPs emotions within the framework of
Balint groups, while Nettleton et al. (2008), studied the emotional aspects of medical work.

6.1.2 Contribution to the Research Methodology

This study makes an original contribution to the research methodology because it is the first to use an interpretive phenomenological approach to interview a group of medical professionals not usually open to interviews. The interpretive research paradigm of hermeneutic phenomenology supported the understanding of the individual experience of each GP. Part of the uniqueness of this study is that my ability as a nurse researcher enabled me to engage GPs to speak openly, reflect, and share their emotional experiences of prescribing.

6.1.3 Theoretical Contribution

The original theoretical contribution is that this study has described feelings such as fear of loss of reputation, fear of running overtime, frustration with being challenged, arrogance at wanting to be right and in control, sadness at situation of patient, which supports understanding of the complex intuitive response in clinical decision making and prescribing. External influences such as time pressures and patient demand trigger the GP’s emotions and intuitive feelings, which drive and determine their clinical prescribing decision (see figure 9). Previous studies have suggested that internal and external influences drive clinical decision making (Bradley 1992, 1993), (Essex and Healy 1994), (Stevenson 1999), (Stolper et al. 2009). However, this study suggests otherwise.

<table>
<thead>
<tr>
<th>Emotionally Driven Decision Response</th>
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<td>Influence ➔ Triggers ➔ Emotion ➔ Intuitive Feeling ➔ Drives ➔ Prescribing Decision</td>
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Figure 9
I have termed this response the “EDD” response, because it is an emotionally driven decision response. The influence triggers emotions and intuitive feelings, which drive and determine the prescribing decision, (figure 9).

While the concept of the emotionally driven prescribing decision may be a new phenomenon to medicine, within American sport, research studies have attempted to understand emotional decision making associated with the so-called home field advantage\(^\text{13}\) (Jamieson 2010, Moskowitz and Wertheim (2011). What this study and the American studies have in common is the finding that emotions are key drivers for decision making.

### 6.2 Limitations of the Study

This study was undertaken as part of an academic award and was therefore undertaken within a strict timeframe, which did not allow a larger scale study to be undertaken. Given more time and resource other methods could have been considered. For example a survey would have supported a larger scale study to be conducted, however a survey would not have reflected the subjective experience of the GPs. Likewise an observational study while allowing the participants to be observed in practice, may have resulted in the GPs changing their behaviour and therefore not a true reflection of their experience.

I have focused on general practitioners and their lived experience of antibiotic prescribing. I purposefully excluded other healthcare settings where antibiotic

\(^\text{13}\) Home field advantage is a term used to describe a perceived psychological advantage that the home team has over the visiting team as a result of playing in familiar facilities and in front of their own fans (Jamieson 2010). However, Moskowitz and Wertheim (2011) found that sporting officials such as umpires and referees create a home field advantage because they feel the emotion of the home crowd, which triggers their own emotions and drives their unconscious sporting decisions. Any bias towards the home crowd is entirely involuntary.
prescribing takes place. In this study, I have not, and did not intend to reflect the experiences of patients registered with GPs (chapter 6, section 6.3).

This study was confined to a small area in the south of England and included GPs from urban rural and semirural practices; as such the findings may not represent the lived experience of all GP Prescribers. Female general practitioners, though not excluded from the study, did not come forward. Therefore, the sample size was limited to ten male general practitioners and their unique lived experience may not be representative of all. Some of the limitations of this study are drivers for further investigation and this is addressed in section 6.3.

6.3 Implications for Practice, Education and Research

This study gives an insight into the living world of medical practitioners in general practice and contributes further to the body of knowledge. However, the findings and limitations of this study have implications for practice, education and research.

6.3.1 Implications for Practice and Education

The findings of this study suggest that GPs emotions drive their clinical decisions. Trainee GPs undergo communications training but emotions are not considered. Emotional awareness is an element of reflective practice and should be included within GP training. Reflecting on the concept of the Balint groups will support GPs to be aware of their emotions and the ways in which emotions may affect the clinical consultation.

The GPs in this study suggested that they felt hindered by the ten minute consultation (chapter 5, section 5.3.2). Building flexibility into the consultation time will improve the quality of the consultation, the quality of decision making, and patient
satisfaction. GP trainees should be taught change models to improve the quality of the general practice consultation.

The GPs interviewed did not appear to use evidence-based medicine as the foundation of their clinical decision making, choosing instead to use their experience, expertise, and intuitive feelings (chapter 5, section 5.0.1). However, without evidence based medicine, GPs’ clinical practice would be out dated and the delivery of high quality safe care may be compromised. This finding will be shared with Health Education England (The Deanery) and the Local Medical Council to help shape and inform the educational curriculum for GPs and GP trainees.

The therapeutic effect of the counsellor is well researched and understood (Jacobs 1999). However, this is not reflected within medicine. Balint (1964) termed the phrase the drug doctor after recognising the therapeutic affect some doctors have on their patients (chapter 5, section 5.0.3). In this study, the GPs underplayed their therapeutic role. GP trainees should be taught the concept of the drug doctor and the effect of self in the GP and patient dynamic.

The GPs in this study felt the pharmaceutical industry did not directly influence their prescribing decisions (chapter 5, section 5.2.4). However, my findings show the pharmaceutical industry may indirectly affect GP prescribing decisions. GP training should include reflections on prescribing practice to support GPs to recognise and understand how influences such as the pharmaceutical industry affect their prescribing decisions.

This study did not intend to focus on the patient experience of general practice. However, the findings of this study demonstrate that GPs do not always involve
patients in the clinical decision making process, even though joint decision making is the patients’ right (chapter 5, section 5.0.2). GP training should focus on the delivery of quality outcomes and include improving the patient experience through the patient centred consultation and shared decision making. The outcomes should then be measured through patient surveys and the friends and family test.

The GPs in this study often faced vague symptoms with no obvious clinical diagnosis and the unpredictability of uncertainty caused them to feel uneasy (chapter 5, section 5.1.4). Developing educational strategies would support GPs in their management of clinical uncertainty and thus reduce some of the associated stress.

The GPs in this study did not consider the risk of *Clostridium difficile* when prescribing antibiotic therapy. This finding was not discussed because the study focused on the lived experience of antibiotic prescribing in the context of medical prescribing (chapter 4, section 4.1.3). However, there is a known correlation between *Clostridium difficile* and antimicrobial prescribing (Minson and Mok 2007). Therefore, GP education should include a pathway approach for infection prevention and control and the management of the potential risks associated with prescribing antibiotic therapy to known high-risk patients. The concept of stringent antibiotic stewardship would support GPs in their prescribing practice.

### 6.3.2 Implications for Research

This study recruited a small sample of ten male general practitioners; therefore, the findings may not be representative of all GPs. Undertaking a larger scale study that uses the same methodology as this study, may determine if these findings are representative of the majority of GPs.
As this study was limited to male GPs (Chapter 3, section 3.3.2), my findings do not include the experience of female GPs. To determine if female GPs' experience of antibiotic prescribing in the context of medical prescribing reflects the findings of this study, a replica study recruiting female general practitioners could be undertaken, as this would enable comparisons between the findings. Furthermore, a replica study would allow their unique lived experiences of antibiotic prescribing to be explored, interpreted, understood, and shared.

The GPs interviewed often used intuitive feelings in the decision making process, yet the concept of intuitive feelings and the role intuitive feelings play in medicine is not yet fully understood (chapter 5, section 5.0.1). It was beyond the remit of this study to explore the reliability of intuition and intuitive feelings. Therefore, further exploratory research may help to understand the role and reliability of intuitive feelings in general practice decision making.

Of particular interest would be further research investigating whether some of the aforementioned factors such as time pressures, managerialism, bureaucratic control, and power, are unique to and/or a result of socialised health care. Researchers could compare the results from this study undertaken in the United Kingdom, with results from a similar study conducted in a country with privatised health care, such as the United States.

Time pressure played a role in the GPs' decision to prescribe or not and sometimes the GPs did not have time to explore the underlying reasons for the patient consultation. These time constraints are enforced to aid GPs in managing the heavy patient load associated with socialised medicine; although it is clear from this study that a ten minute consultation window is often neither sufficient for the GP nor
especially beneficial for the patient. Further exploratory research would help to understand what kind of impact time pressures have on patient care, GP error, and ultimately the mortality rate of patients resulting from misdiagnosed and untreated illnesses.

This study has shown that maintaining a good professional reputation is important to GPs (chapter 5, section 5.3.1). GPs felt their professional reputation reflected their clinical credibility. However, there was very little literature found that focused on professional reputation in general practice. By exploring further the factors that affect professional reputations, it may be possible to determine if there is an emotional effect on GPs.

This study focused on the experience of prescribing antibiotics; however, other frequently prescribed drugs such as statins and antihypertensive drugs may also require additional research to further understand the key drivers for prescribing these groups of drugs. The experience of prescribing and the themes and trends that influence prescribing of these drugs may then be better understood.

Some of the findings of this study may resonate with nurse prescribers particular those working within general practice. However, the exact prescribing practice of nurses in general practice is not known and therefore requires further investigation.

**Summary**

I reviewed the research methodology and presented the original contribution of the study, before highlighting the study limitations and proposing the implications for practice, education and research. Next I present the conclusion of the study.
6.4 Conclusions

In conclusion, this study has shown that GPs feel many emotions working within general practice and their emotions oscillate between feelings of ease and satisfaction, to feelings of unease, stress, and frustration. Sometimes GPs feel heavily burdened by the pressures associated with general practice. The findings of this study (chapter 4) and the subsequent discussions (chapter 5) have demonstrated that clinical decision making in medical prescribing is multifaceted. GPs employ a number of different strategies to reach clinical decisions, which include using their clinical knowledge, their professional experience, and their intuitive feelings. Intuitive feelings are an unconscious emotional response that GPs experience due to patient stimuli. GPs’ emotions play a key role in intuitive feelings, with the emotion linked to good or bad feelings. The role of intuitive feelings in clinical decision making is not yet fully understood. However, it is clear that there is a link between intuitive feelings, professional experience, and expertise, though it remains unclear how long a GP must practice before being classified as an expert.

Patients have a right to be involved in clinical decision making but this right is not straightforward. Sometimes GPs exclude patients from the process and sometimes patients chose not to be involved. The role of a medical prescriber can be one of power and GPs feel powerful because they have the clinical skills, knowledge, and competencies that their patients do not. However, when patients exert their power, the balance tips and GPs often feel powerless. Yet, GPs have the power to change the way patients see and comprehend their ill health but in order to do so they need to build the GP and patient relationship and develop an emotional rapport with their patients.
Though most GPs try to be inclusive when considering treatment options, they do not always foster an equal doctor and patient relationship. The social media and Internet provide patients with medical insights that historically they did not have. As such, managing some patient expectations evokes emotions of stress and frustration in GPs as they manage such challenges. GPs say they are caring professionals who feel empathetic to their patients but they sometimes fear that becoming too attached puts them in danger of feeling overwhelmed or burned out. GPs regularly face vague and complicated symptoms that are not easily identifiable because the most significant factors for diagnosis are absent. Although trained to manage diagnostic uncertainty, the unpredictability of uncertainty sometimes causes GPs to feel anxious and uneasy.

Many influences affect prescribing decisions and each influence evokes different emotions in GPs. For example, GPs often feel pressured by patients to prescribe. When feeling pressured by time, prescribing is often a quicker and less stressful option than entering into lengthy negotiations with patients. Implementing national and local policies is another example of how an external influence, evokes emotions. GPs feel frustrated because they believe policies are often didactic and restrictive to practice. Relationships with the pharmaceutical industry have changed and the industry may no longer have a direct influence on prescribing decisions. Nevertheless, the pharmaceutical industry remains an indirect influence on the choice of drugs prescribed.

Feeling clinically credible is important for GPs and maintaining a good professional reputation is essential. Negative opinions of GPs can sometimes be unfounded, yet such opinions can easily damage professional reputations. While GPs are fully aware of how easy it is to damage their reputation, they feel both vulnerable and powerless
to control this situation. Building and maintaining a good doctor, patient relationship that is patient centred may be an essential factor for clinical credibility. GPs want to be recognised as clinically credible professionals by their GP colleagues.

This study has shown that GPs are caring professionals who try to show empathy without forming emotional attachments to their patients. Some of their prescribing habits may have created an industry whereby patients have forged a dependency on their GP. There are many influences considered in the prescribing decision but ultimately some of these influences become burdens for the GP and this is sometimes a heavy load to manage.

The public commonly consider GPs to be strong, confident, competent professionals, which they are. However, their lived experiences have shown another emotional side, which highlights that GPs have vulnerabilities and anxieties the same as everyone else. Their public facing professional image differed to the one shared behind closed doors.

The unique lived experience of medical prescribers in general practice emphasises that GPs have the best interests of their patients at heart. They want to improve patient outcomes but their pathway for doing so is not always straightforward. This study is unique because it lays bare the GPs’ fragility and emotionality and shows that life, as a medical prescriber is complex. The clinical decision making process evokes both positive and negative emotions in GPs and these emotions ultimately drive the GPs prescribing decisions.
Reference List


Reyna, V. (2008, November/December). Theories of Medical Decision Making and Health: An Evidence Based Approch. *Special Section, Medical Decision Making*.


Appendix 1
Invitation to Participate in the Study

University of Surrey
Faculty of Health and Social Care
Guildford
GU2 7XH

Tel: 01483 300800

Date as posted

Dear Doctor,

The Lived Experience of Antibiotic Prescribing

I am a researcher at the University of Surrey. I am undertaking a study towards the award of Doctorate in Clinical Practice. The study topic is *the lived experience of antibiotic prescribing*. You are invited to participate because you have experience of medical prescribing and I would like you to share your experience.

I will be undertaking face-to-face unstructured interviews that will take no longer than one hour. I will find a time and venue convenient to you.

If you are interested in participating in the study, please return the slip at the bottom of this letter to:

Carol Cassam
NHS xxxxxxx
Xxxxxxxxx
Xxxxxxxxx

Email: 
Carolcassam@nhs.net

If you have any questions please do not hesitate to call me on: 07956075814
Appendix 2  
Information Sheet for GP Participants

Dear Dr ---

Following your expression of interest, you have been selected to participate in the following study:

The lived experience of antibiotic prescribing.

Carol Cassam is undertaking this study as part of a doctoral program at the University of Surrey in Guilford. The following information gives you some background about the study process.

**Purpose of the study**

The purpose of the study is to examine the experiences of antibiotic prescribing in the context of medical prescribing. This is an area that has not been researched extensively.

**Location**

The interview will take place in a location and venue of your choice at a time that is convenient to you.

**Content**

During the interview, you will be asked about your experience of medical prescribing and you may be asked for more information or more detail.
Recording
The conversation will be tape-recorded and transcribed verbatim by Carol Cassam. The audiotapes will be destroyed after the completion of the study.

Concerns
If you are concerned about the interview process or have any queries, you may contact Carol Cassam at any time:

carolcassam@nhs.net
Telephone: 07956075814

Data protection
All information that could identify you will be treated confidentially. In the transcript, your name will be changed and no reference will be made to your place of work. The tapes will be coded with the code known only by Carol Cassam and the tapes will be securely stored in a locked cabinet within an NHS building.

Analysis
Carol Cassam will transcribe your interview verbatim and you will have the opportunity to read the transcript to ensure that the interview is interpreted truthfully. You have the right to ask for comments to be changed or removed.

The Study Findings
The findings from the study will be published to add to the body of knowledge but you will not be identified in any way.

Your Rights
Your participation in this study is purely voluntary. You have the right not to respond to any question asked and you are free to withdraw from the study at any time. You can ask for the interview to be stopped or for a comment to be deleted from the tape. You can ask that I not use any notes I may have taken during the interview.

**Costs and Payment:**

You will not receive any payment, incentive or reward for taking part in this study.

If you have any questions, please contact Carol Cassam either by email or telephone as given above.

Thank you for participating in the study.
Appendix 3
Consent Form

Purpose of the study
I understand this study aims to explore the lived experience of antibiotic prescribing in the context of medical prescribing and this has been fully explained to me.

Data Collection
The process of data collection has been fully explained to me and I understand and agree to the interview being tape-recorded. The interviewer will transcribe the recording and no other person will have access to the recording. The recording will be destroyed once transcribed.

I will receive a copy of the transcript to validate that the interview has been truthfully interpreted. I understand I can ask for comments to be removed from the transcript.

Participation in the Study
I understand my participation in this study is voluntary; therefore, I can withdraw at any point, without giving an explanation/reason.

I understand the themes and trends that emerge from the interview will form the basis for the research report.

I agree for the report to be published and used to build on the body of knowledge. I understand that I will not be identified in anyway and no reference to my identity or place of work will be made.

Confidentiality and Anonymity
I understand I will not be identified in any way and will remain anonymous and I understand I can ask to have a comment deleted from the tape.
Duty of Care
I understand that should any areas of bad practice emerge, the researcher has a duty to discuss the issues with her supervisor and PCT general practice commissioning lead.

Location for the Interview
I understand that I will identify the location and venue for the interview and the interview will take place at a time convenient to me.

Costs and Payment
I confirm that I have not received nor will I receive any payment, incentive or reward to participate in this study.

Participant Consent
I hereby fully and freely consent to participate in this study

Contact Details
I understand that I can contact the researcher, Carol Cassam, at any time if I have questions and concerns or if I should change my mind and wish to withdraw from the study:
Carolcassam@nhs.net
Telephone 07956075814

Participant

Name                                                Signature                            Date

Researcher

Name                                                Signature                            Date
Appendix 4
Interview Guide

Introduction

This is an unstructured interview; therefore the questions are intended to support the researcher and may not be asked sequentially.

1) Opening Question
   • How long have you been a practicing GP?

2) Antibiotic Prescribing
   • Can you tell me about what influences you to prescribe antibiotic therapy?

3) The lived Experience
   • Please can you tell me about your experience as a medical prescriber?
     Please take your time, I will not interrupt you. I may make a few notes as you speak but should you find this distracting please tell me.

3) Researcher Prompts
   • Can you tell me a little more about that please
   • I think what you are saying is
   • How does that make you feel
4) Follow up Questions

The following questions may be asked when the interviewee has finished sharing their experience of prescribing. Dependent on the information shared through the lived experience, I may not ask all participants all questions.

- How do you make a decision to prescribe antibiotics?
- Can you tell me about the scriptswitch system?
- Can you tell me about the pharmaceutical industry and the drug representatives?
- How does the computer decision support system assist you in clinical decision-making?
- How do you involve the patient in the decision making process?
- What risks do you consider when prescribing antibiotic therapy?
- Can you tell me about the risk of *C. difficile*?
- Can you tell me what you consider when prescribing an antibiotic to patients that take a proton pump inhibitor?

5) Closing the Interview

Is there anything else you would like to add?

Thank you for sharing your experience with me. You will have the opportunity to read the transcript to ensure I have truthfully interpreted the interview. Are you happy for me to make further contact with you?

Thank you very much for your time.
Overview of the Integration of Knowledge, Research and Practice

1.0 Introduction

This overview paper provides an insight into how the taught modules of the Doctorate programme supported integration of knowledge, research, and practice, gained through the academic experience. The taught components of the programme provided the foundations for the final research study. In order to progress to the research study, three formal written assignments had to be successfully completed.

1) The Policy Review
2) Service Development project
3) Research Proposal

As a mature student undertaking part time long distance study, I had to discipline myself to self-directed learning. I came into the programme with a level of knowledge and competence and I was aware that I would need to learn new skills and enhance my knowledge of research in order to complete successfully the Doctorate programme. I mapped my learning using the competency ladder (Burch 1970) as shown in figure 1. Using this model not only highlighted my skills progression but it also reflected my emotions as I moved through the competency levels. My entry point to Doctoral studies was level 2. However, during the taught modules and subsequent research study, my skills and knowledge increased to level 3 and 4. I had a conscious awareness of my emotions and through the learning process, I was mindful of what I did and did not know. For example, while I had previously produced academic assignments for taught courses, I was aware that skills of critical thinking needed to be developed in order to reach the standard required for Doctorate level study and publication in peer-reviewed journals. In addition, I initially lacked skills of
statistical analysis but developed from being consciously incompetent to consciously competent at using statistical analysis packages.

<table>
<thead>
<tr>
<th>The Competency Ladder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3</strong></td>
</tr>
<tr>
<td>Conscious Competence</td>
</tr>
<tr>
<td>Acquire new skills and knowledge. Able to apply learning into practice. Confidence in undertaking new role. Awareness of new skills and set about refining them. Conscious awareness of new knowledge with practice and experience, these become increasingly automatic.</td>
</tr>
<tr>
<td><strong>Level 4</strong></td>
</tr>
<tr>
<td>Unconscious Competence</td>
</tr>
<tr>
<td>New skills become habits and tasks are performed without conscious effort and with automatic ease.</td>
</tr>
<tr>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td>Unconscious Incompetence</td>
</tr>
<tr>
<td>Lack of knowledge and skills in the subject. Unaware of the lack of skill and confidence may therefore far exceed your abilities.</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
</tr>
<tr>
<td>Conscious Incompetence</td>
</tr>
<tr>
<td>Aware there are skills to be learnt. Uncomfortable period as these new skills are learnt. Others appear more competent.</td>
</tr>
</tbody>
</table>

**Figure 1**

2.0 Learning through the Peer Group

Starting university was an exciting experience and the other Doctorate students were welcoming and supportive. The peer group quickly became integral to my learning and development. As a small cohesive group, we felt comfortable in sharing knowledge and experiences. For example, after class we would discuss and talk through theoretical concepts until we shared an understanding, with no one of us feeling disadvantaged by uncertainty. Our discussions developed critical thinking and facilitated understanding of each other that allowed openness, honesty and transparency.

3.0 Learning through the Taught Modules

During the first two years, the taught modules broadened my knowledge of research, leadership styles, and leadership skills. Hearing a sociological and an anthropological perspective on health research was both new and exciting for me and helped to develop my thinking beyond the nursing framework of the NHS. The modules allowed
me to question and challenge practice and I began thinking in a more innovative and creative way and tried to do things differently, for example, devising a set of quality indicators that became part of the commissioning cycle. 

I developed further my skills as a reflective practitioner and began to explore ways to be more effective, efficient, and to achieve better outcomes, for example, developing a pathway approach to improve patient outcomes for healthcare associated infections. I began to appreciate that undertaking this programme, though tough and challenging, gave me an opportunity to push boundaries and question and challenge how and why we do things in healthcare. The integration of the knowledge gained from the taught modules is described below under the respective module heading:

3.0.1 Power, Policy and Politics
The first test of academic ability was the policy review. Undertaking the module gave me the confidence, for the first time, to really take apart a national policy and question and challenge the rationale. I chose The Health and Social Care Act- The Code of Practice (The Hygiene Code) because I initially thought infection control would be the basis of my study. The policy analysis tool was taken from the document, Professional Policy making for the Twenty First Century and developed by The Strategic Policy Making Team at the Cabinet Office. The skills learned through the module supported me to review the policy and critique the analysis tool. The Department of Health had not considered implementation because there was no implementation or educational plan to guide NHS organisations. The disparity between the Cabinet Office’s ideals for policy development process and the process and development of the hygiene code became obvious to me and I felt confident enough to air my views to the Department of Health through the Code of Practice Working group. This was a turning point in my development because I had never
before stepped forward to take part in national debate. Undertaking this module gave me the confidence to contribute critically and effectively to health policy debates and consultations.

3.0.2 Advanced Research Methods

Learning research methodologies and statistical analysis initially felt like a whole new language but it soon became a language I could not only speak (albeit as a novice) but could begin to understand. This module opened my eyes to research methodology and design. Advancing my research skills has supported me throughout the research study.

Choosing a methodology that fitted with my research question gave me the opportunity to look in depth at the different approaches. I initially considered grounded theory but realised that a phenomenological approach would allow me insight into the research participants’ lived experience. I valued the expert knowledge of my supervisors in clarifying language that was new to me and for guiding me to works such as Heidegger and Husserl. I began to explore interview techniques and how best to extract quality data from the participants. I chose an unstructured interview style to allow the participants to speak freely of their lived experience. I initially scoped the literature to determine what was already known of the lived experience of antibiotic prescribing and realised that there was a gap in the literature in this subject. This became the justification for the study.

A combination of the leadership course and the advanced research methods module gave me the confidence to step outside the boundaries of nursing. I carefully considered the feasibility of interviewing GPs. Knowing that GPs are not usually open to being interviewed; I was initially concerned that as a nurse researcher GPs would
be unresponsive to my request to participate in the study. However, my concerns were unfounded. I now felt confident to move forward and develop the design for the study and seek ethical approval.

3.0.3 Leadership Styles

As an NHS manager, learning leadership styles helped me reflect and explore my own style and build on those skills to become a confident and effective leader. Undertaking role-play and peer review, supported reflection in action (Schon 1983) and I realised I needed to be more confident at presenting papers at Board level. While familiar with talking to GPs, I recognised the need to develop further leadership skills in order to be recognised as a confident and competent leader of a research study. The module enhanced my leadership skills and supported me to appreciate the differing styles of leadership and situations where they may best be used.

3.1 The Research Study

Collectively, the taught modules gave me a solid foundation on which to build my research study. Writing the research proposal helped me clarify the purpose and aims of the research study and how the aims would be achieved. By considering what I had learned in the research methodology classes, I began to see where I wanted to take my research. I chose hermeneutic phenomenology because it would support me to explore the lived experience of prescribing. I read and reread until I understood and felt confident that my methodology was relevant to my chosen topic, my research aim, and my research question. When I undertook the research interviews, I followed the three basic ethical principles of non-maleficence, respect for participants and justice (Beauchamp and Childress 2001).
The unstructured interviews allowed the GPs to share their experience openly and prompts were used if further depth was needed (Appendix 4). The support and advice from my supervisors was invaluable and their expertise of research and interview styles helped me shape the interviews. GPs were receptive to me and openly shared their experience of medical prescribing and the interview process allowed me to see hermeneutic phenomenology in action. As I worked through my schedule of interviews, my confidence grew as my interview skills developed.

I initially felt both excited and overwhelmed with my transcripts because I had so much data. I called upon the skills learnt in the Research Methods model to transcribe and analyse the data and the expertise of my supervisors to support me in applying analytical methods to extract the rich data. I began to work through the analysis methodically and soon found myself immersed completely in the data, which I worked through until my transcripts were complete. This method of analysis helped me to interpret and understand the experiences that the GPs had so openly shared with me. The research log provides an overview of the progress from data analysis to writing up the findings chapter. Writing up my study was satisfying and frustrating as I wrote, read, and rewrote until I felt satisfied with each chapter. My skills of writing at doctoral level developed, as did my ability to think critically and creatively. The expertise of my supervisors helped shape my final thesis.

Summary

Undertaking this Doctoral study has supported my learning and development both personally and professionally. I not only learned from the expertise of the academic tutors but also gained support and knowledge from my peer group. The Doctoral programme gave me the tools to develop my knowledge and experience, which will support me with future research and academic writings. The study has required
investing much time, energy and effort to reading the literature, thinking creatively and critically, and finally reflecting my learning within my study. I gained new research knowledge, skills, and knowledge of medical prescribing and the decision making process. This period of academia has brought rewards because I am a more confident leader and not afraid to step outside the boundaries to explore new ways of thinking and working. Professionally I have learned how to undertake an exploratory study and in doing so have developed my skills as a researcher, particularly in interviewing a group of professionals not normally open to interviews. I have developed my knowledge and understanding of decision making within clinical practice and my enhanced skills of creative thinking helped me develop original concepts. I have learned how interpretative phenomenology supports the exploration of experience. The reflexive nature of phenomenology helped me develop a deeper understanding of the research phenomenon known as the lived experience of antibiotic prescribing.

The challenges of undertaking this study have been great but the study has also given me a sense of achievement and satisfaction, because looking into the world of prescribing and hearing GPs’ experiences first hand was a privilege. Now that my study is complete and I sit and reflect, I appreciate how far I have come. I have learned much and developed my personal and professional skills, which have supported me in becoming a more efficient and effective NHS manager and leader. Undertaking Doctoral study has encouraged me to continue with research and to seek out opportunities to write for publication.
Reference List


Research Log

Introduction

This research log is a retrospective reflection of the research journey taken from my contemporaneous research diary and it is loosely based on the reflective components of Kolb’s Model of Experiential Learning (1984). The phases from the taught modules to the research study are described. The log provides an insight into my experience of academia and the personal and professional challenges faced during the Doctorate programme.

As a registered nurse, district nurse, community practice teacher, and independent nurse prescriber, my passion for delivering high quality safe care was the driver for me to undertake Doctoral level study. As I began my studies, I did not realise that I would face many personal and professional challenges along the way. During the duration of this study, I learned great deal and not only developed academically and professionally but personally as well.

Peer Support

My peer group was small with just five students; however, we became a means of academic and emotional support for each other. We set up our own study groups and social events outside of the university. Discussing ideas for assignments and the research study enhanced critical and creative thinking, while maintaining both motivation and pace.
The Taught Modules

Politics, Policy and Power

Undertaking the policy review empowered me to question and challenge policy development. For the first time I began to understand some of the political drivers that force change at the clinical practice level. Reviewing the Health and Social Care act, The hygiene Code, supported my understanding of how the power balance remained with the Department of Health, while the accountability and responsibility for delivering and ensuring compliance with the policy sat firmly with the commissioners of healthcare. The policy emphasised effective antibiotic prescribing, which linked to the embryonic study idea of exploring the lived experience of medical prescribing.

Advanced Research Methods

This module opened my eyes to the different research methodologies and designs. While there was no formal assignment for this module, as a small group we spent much time in the class environment discussing how, why, and when different methodologies and research designs would be used. I began to learn how to critique research and explore ideas for my research topic and the research approach I would use. I initially considered grounded theory and looked at studies that had used this methodology. However, on discussion with my supervisors I realised that in order to understand the lived experience, phenomenology was a better fit. I began to read and question until I felt confident to use interpretative phenomenology as my research methodology.

Leadership in Health Care Organisations

This module was inspirational for me, as I began to understand the difference between leadership and management. In the classroom environment, we undertook
role-play, which felt uncomfortable particularly when peers critiqued one's chosen leadership style. However, as uncomfortable as role-play was, it led to valuable learning and I began to appreciate how I could become a more effective and efficient senior leader. I did not realise at the time how much strong leadership would be needed in the future as I led my team through the NHS reform and a period of transformational change. Looking ahead, sound leadership skills will be invaluable for future when sharing and disseminating the findings of my study and raising awareness of the emotional side of GPs. The skills learned from the leadership module gave me a solid foundation to demonstrate to the GP participants that I was a confident and competent lone nurse researcher, leading a qualitative research study.

**Service Development**

The service development project allowed me to explore more effective and efficient ways of delivering high quality safe care. The project was undertaken to determine the possible causative factors of *Clostridium difficile* cases in community patients and involved the analysis of 106 *Clostridium difficile* root cause analysis. Findings identified themes and trends pertaining to poor prescribing practice within primary care. The results of this project brought about further work streams within antibiotic prescribing including antibiotic stewardship. Analysing medical prescribing trends was another driver for understanding the lived experience of medical prescribing.

**Planning the Research Project**

**My Research Proposal**

Undertaking a 10,000-word research proposal seemed like a mammoth task in the early days of my research journey and led to many discussions with my supervisors. I had initially considered using grounded theory but after seeking the expertise of my supervisors, I realised that grounded theory would not give me the insight into the
lived experience of my participant group. After reading and learning about interpretive phenomenology, I began to appreciate that this methodology would support me to understand the lived experience of prescribing. It was hoped that my findings would inform the body of knowledge because little is known about the lived experience of general practitioners (GPs).

**Ethical Approval**

A more succinct version of the research proposal was submitted to the local Ethics Board and the University Ethics Board. Permission was granted for me to undertake the study, which meant I could now commence the recruitment phase of the study.

**The Research Study**

The research Study used an interpretative phenomenological approach to explore the lived experience of antibiotic prescribing. The motivation for the study was based on wanting to understand more about antibiotic prescribing in the context of medical prescribing and how it feels to be a medical prescriber. Following discussions with general practitioner colleagues and my supervisors, the embryonic study idea became a reality. Supervision, support and guidance came from my supervisors Professor Helen Allan and Dr Vasso Vydelingum.

**Supervision Sessions**

My supervisors Professor Helen Allan and Dr Vasso Vydelingum set up regular supervision sessions. However, it was not always easy for me to attend the supervision session because the challenge of the M25 meant that travel was unpredictable and despite allowing ample travel time, my plans were sometimes hampered by traffic jams. Additionally, as a senior manager working full time it was often difficult to plan time that fitted with my supervisors’ busy schedules. To ensure regular contact, face-to-face supervision sessions were alternated with a
teleconference. Figure 1 provides a summary overview of my supervision discussions and milestones throughout the course.

<table>
<thead>
<tr>
<th>Overview of Supervision Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year</strong></td>
</tr>
</tbody>
</table>
| 1. | • Discussion of advanced research methods and begin to think about research topic  
   • Reviewed *The Health and Social Care Act, Hygiene Code* for formal assessment  
   • Explore research methodologies in line with chosen research topic |
| 2. | • Discuss ideas for research topic and draft 10,000 word research proposal  
   • Rethink research methodology, grounded theory does not fit with my research aim  
   • Explore the concepts of interpretative phenomenology  
   • Meet with Professor Helen Allan to discuss using phenomenology  
   • Draft a project plan and timeline as a Gant chart  
   • Identify area of service development and draft for formal assessment  
   • Preparation for presentation of service development project to peer group |
| 3. | • Draft proposal for Local and University Ethics Committee  
   • Discuss outcome of Ethics Committee at supervision session  
   • Commence recruitment of GP participants  
   • Discussed unstructured interviews and the use of tape recorders  
   • Commenced interviews and commence write up of research methodology chapter |
| 4. | • Progress with interviews and data collection  
   • Struggling to stay on track due to family bereavements and pressure of work. Discussed taking a break from the programme  
   • Applied for a break under extenuating circumstances, agreed by panel  
   • On return to study complete remaining interviews  
   • Manually analyse existing qualitative data using interpretative phenomenological analysis  
   • Discussed how to manage so much data  
   • Resubmit project plan to reflect new completion date  
   • Submit transcripts to supervisors  
   • Discussed study time in light of work pressures and changing NHS  
   • Date set for completion of data analysis  
   • Commence write up and date set for submission of findings chapter to supervisors |
| 5. | • Discuss progress and draft second iteration of findings chapter |
The Annual Review

Throughout the duration of the programme, I attended five annual reviews, which gave me the opportunity to reflect on my academic progress and identify milestones for the following academic year. The milestones informed my objectives and helped in identifying perceived difficulties for achievement. The discursive style of the review allowed for reflection on action and helped me think of ways to be more efficient at balancing the challenges of full time work with the demands of Doctoral level study (Schon 1983)

Personal Challenges

While immersing myself in my study, I had two family bereavements in quick succession. Firstly, my young nephew died of cancer; he was 8 years old. Five months later, my mother also died of cancer. These events were real low points for me and after speaking with my supervisors I realised I needed a short break from my studies to allow myself time to grieve, face my losses, and begin to heal. These challenges drove me on and I was determined to complete the study for my mum. I
thought of my young nephew who would never have the chance to achieve all that he may have had he been able. I was not about to waste the academic opportunity afforded to me and I was determined to complete my study, so I returned after my short break.

Returning to my Study and Peer Support

Upon returning to my study, I reflected on my journey so far and what I needed to achieve. I realised I was now a lone student as two of my peers had completed their studies and the remaining two had withdrawn from the programme. I now lacked the peer support, which I had previously found so valuable but I picked up from where I had left off and completed the study.

Undertaking a Research Study during NHS Reforms

My study took place during a period of transformational change in the NHS. This was a time of uncertainty because as an employee within a Primary Care Trust (PCT), I knew the government intended to abolish PCTs and develop GP led Clinical Commissioning groups (CCGs). I continued to undertake my role within the PCT while at the same time supporting the development of the quality agenda with four CCGs. During this time, stress levels were high for all involved in the transition and I had the added stress of undertaking my study. However, I called upon the leadership skills I had learned within the taught modules of the doctoral programme and led my team through this transitional phase. I used my knowledge of stress management to keep myself on track with my study.
Professional Development

Throughout the course, I have attended two research workshops, at the University of Kent in 2009 and 2010. In preparation for the Viva, I am currently seeking out an opportunity to attend Viva training as discussed with my supervisors.

I presented the service development project at a national infection prevention and control conference in Leeds. I am now better equipped to understand research methodologies and critically analyse academic writing. I have learned stress management techniques, particularly in relation to prioritising, which has helped with personal and professional stressors. My job as a senior manager calls for flexibility and does not conform to 9-5 working rules. I realise I must not always be so obliging and I have learned to delegate more.

Competing demands of personal, work and university has at times been difficult to manage. Though my managers were supportive, in April 2013, my study time was cut to 2 days per month; therefore, I had to keep pace to ensure the study was completed to time.
Reference List
