Heartlift patients? An interview-based study of GP trainers and the impact of ‘patients they like’

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**Background.** The concept of the ‘heartsink patient’ is well known and much used when talking about general practice. The opposite of this type of patient, however, has been little explored.

**Objective.** To identify patient characteristics valued by GPs.

**Methods.** Structured interview to collect narratives from GPs of individual patients, analysed qualitatively through thematic analysis and word frequency.

**Setting.** Primary Care in Ireland.

**Participants.** GP trainers.

**Main outcome measures.** Emergent themes from four lead questions: Tell me about a patient you like, Tell me about the patient’s personality, What have you learned about yourself as a GP?, What is different about being a GP as opposed to any other kind of doctor? In addition, a corpus linguistic analysis of word frequencies disclosed further themes, not identifiable on the surface of discourse.

**Results.** Ten themes were identified: GPs valued patients who were likeable, a challenge, involved them in negotiation of the doctor–patient relationship, were interesting or virtuous and had a positive effect. GPs valued their profession in that they were facilitators, gave and elicited loyalty, formed personal attachments and had a different perspective.

**Conclusions.** ‘Heartlift patients’ may be a robust concept, to counterbalance heartsink patients. Data collected are suitable for training, and could help GPs enhance a sense of vocation.

**Background**

Since O’Dowd’s paper,1 the phrase ‘heartsink patient’ has become ‘part of the vocabulary of general practice’.2 Dealing with such patients, O’Dowd said, was “a lonely journey that many doctors make regularly”, and “…we need help with this problem because we are part of it, and thus find understanding of it difficult.” Since then, understanding has increased.3 Mathers et al.,4 for example, found that sixty per cent of the variance in the number of heartsink patients … practitioners reported … could be accounted for by …: greater perceived workload; lower job satisfaction; lack of training in counselling and/or communication skills; and lack of appropriate postgraduate qualifications.

Indeed, it has been argued5 that the term ‘difficult encounter’ rather than ‘difficult patient’ better reflects the reciprocity of the ‘doctor–patient relationship’. Similarly, Wilson,6 arguing that “there are relatively few doctors who explore their personal reactions to patients in a deliberate way,” emphasizes that it is the doctor–patient relationship which is in question, and—as O’Dowd himself suggested—advocates training in reflective practice.

No parallel research study exists about patients whose characteristics help to make medicine rewarding. Although the term ‘heartlift’ has been proposed for such patients,7,8 there has been little parallel dialogue either. At a time when “a protocol driven … system of monitoring and rewarding” can seem ‘a potential threat to intelligent and humane practice’,9 there is a need to capture and foster positive aspects...
of the profession. This study asks GPs to identify some of the rewards that patients can offer.

Methods

To find out more about the type of patient favoured by GPs, the doctor–patient relationship and the reasons why our interviewees chose these people as their preferred patients, an interpretative study of structured interviews was designed. We used two different qualitative methods of analysis to fully explore the doctor’s narrative, namely a thematic analysis approach and a corpus linguistic technique. Both analyses are inductive and make no claim to generalizability, but are known to give detailed insight into the construction of the narrative and identification of themes.

Participants

GP trainers in Ireland were selected because (i) they were a well-defined group and (ii) it seemed likely they, like many GPs in fact, would offer articulate and reflective narratives. At the time of the study, there were 158 GP trainers working in Ireland. These were randomly assigned a number from 1 to 158 and approached, until 30 trainers had given written consent to their participation. They were given the opportunity to withdraw consent after the interviews.

Interview structure

GPs were asked four questions in a 20- to 30-minute interview designed to facilitate clinical and personal details of a patient nominated by the GP, who was asked in advance of interview and at the point of consent, to ‘talk about a patient they liked’. Provisional questions were developed by MO and JS. MO then piloted these with three GP trainers and minor adjustments were made, but the questions were found to be suitable as they provided the required information in a timely fashion. MO interviewed all participants at a venue chosen by the interviewee—mainly in the GPs own surgeries. The questions were:

(i) “Tell me about a patient you like”—This allowed respondents to interpret ‘like’ for themselves (easy to deal with, personally admirable or having the basis for friendship);
(ii) “Tell me about the patient’s personality”—This ensured that respondents talked about the patient as a person, rather than a case history;
(iii) “What have you learned about yourself as a GP”?—This invited GPs to reflect on what they learned as a result of being a GP to this patient; and
(iv) “What’s different about being a GP as opposed to any other kind of doctor”? —This helped GPs to stand back from their narrative and reflect at a more abstract level.

The interview structure was designed to collect narratives, in common with standard narrative research technique. This offered researchers the chance to capture patients’ stories and doctors’ reflections, in a rich context which preserved complexity. Data were transcribed using validated conventions, with all authors checking against tapes.

Analysis

A thematic analysis was undertaken by all three researchers independently, with the assistance of NVivo. The identified themes were compared and differences resolved through discussion.

To complement and support the thematic analysis, interviews were analysed using WordSmith Tools version 4, a corpus linguistic software programme. Wordsmith is a corpus linguistic tool that can be used to calculate keywords, i.e. those words which occur more frequently in a particular data set compared to texts of the same type (here, compared to other examples of spoken, interactive language). Most keywords are obvious—the present data set yields ‘patient’ as a keyword, for example—and are therefore on the whole uninteresting. Other keywords, however, are of relevance. By analysing statistically frequent words, one can identify themes in texts which may not otherwise be readily apparent.

Results

Thirty-one GPs were invited to participate by telephone: one declined. The population of GP trainers in Ireland is a relatively small and mutually supportive group, which might explain the high acceptance rate, together with the interviewer’s ability to accommodate the GPs to the time, place and date that suited them. Basic demographic information was collected. Six single-handed practices were represented and 24 group practices (10 urban, 7 rural, 13 mixed). Participants were randomly selected, but figures for male and female trainers mirror the trainer population at the time (23 male, 7 female). The mean age of respondents was 48.47 (range 36–57), the mean amount of years experience as a GP was 19.07 (range 7–30) and the mean years as a trainer was 5.30 (range 1–17).

Themes emerged from the questions as follows (see Table 1).

1. “Tell me about a patient you like”

Three themes emerged (Table 1, Themes 1–3). Patients were ‘liked’ either because they were felt to
be easy to like generally, or because they represented ‘a challenge’ to the GP. Thus, one patient is ‘educated and self manages’, a ‘nice man’, a ‘good member of the community’ [D1]. There may be a ‘particular affinity’ to the GP’s own life, for example to widows ‘because my own mother was a widow’ [D18]; similarly, ‘she reminds me of a countrywoman my mother was a countrywoman’ [D5]. A number of patients were described as challenging. D3’s patient was ‘remarkable’, ‘extraordinary’, ‘fiery’—but ‘the opposite’ of a heartsink patient. D7’s patient was ‘pleasant’, but ‘strong willed’ and ‘well able to negotiate with doctors’. Over coming challenges put forward by ‘difficult’ patients sometimes changed the relationship between doctor and patient; some ‘heartsink’ patients turned into ‘heartlift’ patients. D13’s patient, a lady in her 30s on methadone, was ‘singularly the most difficult into ‘heartlift’ patients. 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say he invited me for a meal or something I think that would probably ruin the whole thing.”

This was clearly an issue which GPs had reflected on, particularly when they were, e.g. likely to meet patients socially, for example, at ‘school functions’ [D11], where both GP and patient had a child attending the school.

The ‘liking’ was sometimes central. D9’s patient was a young woman recently bereaved. The mutual regard of GP and patient meant, as a result, that the quality of medical advice given was perceived as less important than the strength of the personal rather than professional relationship:

I immediately would have liked this girl. I liked her approach, I liked her honesty when she came in. I liked the way she said exactly what was going on em in her head and how she was looking for help.

even if the advice I had given wasn’t the best advice or something had gone wrong that that relationship would have helped anyway.

1. “Tell me about the patient’s personality”

Two themes emerged (Table 1, Themes 4 and 5). Patients who were ‘interesting’ were valued: one elderly lady (aged 94) was appreciated ‘because she was full of the history of the place’, for example [D2]. Many patients had done unexpected things. One was a war veteran with feelings of guilt about a successful military career [D16], one a good artist [D5], one had undertaken long-distance sailing [D15], one had been in the foreign legion [D29]. The other theme to emerge here was that GPs selected patients who represented ‘virtuous’ human qualities. They were ‘kind’ and ‘caring’ [D9] and made the GP realize ‘there are very, very good people out there that deal with a lot in life’ [D6]. Or they were courageous in adversity: “there’s something brave about her and do you know what it is as well, honourable” [D28]. They were ‘cheerful’ through ‘multiple problems’ [D12]; “even through all this … I’d go toots, why aren’t you depressed, why aren’t you mad ..?” [D25].

Some doctors felt their patients had the ability to live well: “If you can aspire to be a personality who does well … pick [name’s] personality” [D1].

Sometimes patient stories were ‘very powerful’ [D14] (this patient was a victim of abuse as a child). Several respondents volunteered ‘admiration’ as a word to describe their feelings.

1. “What have you learned about yourself as a GP?”

There were three themes (Table 1, Themes 6–8). One was the GP’s role as a facilitator of sometimes ‘chaotic and difficult’ lives [D14]. Another was the relationship of trust and loyalty between GP and patient. There was a recognition that trust could be earned, and subsequently tested without breaking. D21 missed a diagnosis with a patient:

and and they they actually brought her to hospital where it was diagnosed and I remember … and … afterwards I said ‘… I really feel awful about it’ and she said “Ah no doctor I mean y’know you kind of checked it out …” and that was extraordinary forgiving on her part.

A third theme was the ‘effect of the patient on the doctor’. Self-esteem might be enhanced: “You like people who affirm your presence” [D11]. Being a GP “meets needs I have as a human … To feel I belong and am valued” [D2].

GPs also felt they learned to be better GPs or learned more about the professional relationship. D19, who found himself needing to rework an inappropriate counselling relationship, said “I learned limits that I had.” D8, whose patient had lost her son, said: “in challenging me as she did I learned more about myself as a GP … and about how far you’re willing to cope with a patient.” D6, who described the lady with bipolar disorder, felt she had learned more about mental health problems. However, the development of professional competence was contextualized in a deeper understanding of the patient’s worth to the doctor as a person:

She’s taught me to be grateful with what you have in life … There’s very very good people out there that deal with a lot in life and if you can facilitate them in any way well that’s your job, that’s all you’re doing.

1. “What’s different about being a GP as opposed to any other kind of doctor?”

There were two themes (Table 1, Themes 9 and 10). One was ‘personal’ attachment, the other was ‘longitudinal’ [D1] ‘perspective’. Other doctors do the technical things, D3 said, “but I’m the doctor.” Of the elderly lady described by D2, he acknowledged, “I’ll be upset when she dies”: “We’re not detached and I don’t apologize for that” [D2]. Beyond this was an attachment to the patient’s family—the ‘other interconnections’ [D7], the fact that, e.g. “I know her husband, I know her kids” [D4].

Part of the context of general practice is the wider perspective [D19]:

we have to keep a very very wide spectrum it’s like the camera you need a very wide angle lens and … other aspects or angles of the profession are getting smaller and smaller lenses all the time almost microscopic
Behind all this, however, lies the possibility of the patient renewing the doctor’s sense of vocation:

I’ve learned really that it’s a very privileged situation . . . and there’s magic moments in the in the career of a doctor meeting her was one of them y’know it’s a very privileged situation to be there . . . and to see the courage . . . really phenomenal courage to see that in action y’know . . . and I’m interested to see her wit and her humour her character and that y’know. So I think that that’s real privilege . . . part of the secret of surviving as a family doctor I think is to . . . well it’s to treasure those moments y’know I think it’s a wealth of treasure y’know unfortunately . . . there is a tendency in our job to quantify in terms of policy and expense when in actual fact it’s not like that y’know it’s a way of life it’s . . . as a another patient who would be second on my list of patients said “It’s a vocation doctor it’s a hard job it’s a vocation and you’ve got to want it” . . . so I learned that from her that the job’s a vocation and you can’t quantify it . . .

1. As a result of the corpus linguistic approach, two more themes were identified. Content words (nouns, verbs, adjectives, adverbs) that occur most frequently in a text are very likely to reveal what themes the text deals with. Most of these words will be very obvious (e.g. ‘GP’, ‘patient’) and the researcher is therefore normally more interested in non-intuitive results.\textsuperscript{16}

There were three words worthy of further investigation, namely ‘time’, ‘years’ and ‘actually’. Each occurrence of these keywords was scrutinized to determine its functional meaning. In consequence, many uses of ‘years’ were discarded as irrelevant (they were responses to the question ‘How long have you been a GP?’)—yet enough occurrences were left for years to remain a keyword. The three keywords indicated two themes: firstly the importance of the ‘longitudinal nature’ of general practice (time, years—theme 11, Table 1) indicating that GPs often have a longstanding relationship with their ‘heartlift patients’. Time seems to be a key aspect in building rapport.\textsuperscript{17} Secondly, ‘the surprising nature’ of the narratives or aspects of them (actually—theme 12, Table 1). Actually is used by the GPs to talk about an unexpected outcome or a characteristic of their patients. For example, “he actually gave up cigarettes completely” or “I’ve actually sort of modified her approach.”

In the case of all three words, as can be seen in Table 2, relative frequency per million words is significantly greater ($P < 0.01$) as measured against parts of the standard 525 million word database held by the University of Birmingham, known as the Bank of English.\textsuperscript{18}

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\textsuperscript{a}Only the four subcorpora of the Bank of English were used, namely the ones containing transcribed spoken English.

\textsuperscript{b}After excluding occurrences of years as described.

### Discussion

This study suggests that the concept of a heartlift patient may be as robust as that of a ‘heartsink’ patient. It also suggests that GPs are like patients in valuing continuity of care. This seems to be embedded in a general sense of ‘knowing the patient’ and having therefore the ability to respond holistically rather than within a purely evidence-based medicine framework.

The study has some limitations, among which there is the risk of social desirability bias,\textsuperscript{19} which can always occur in narrative-based studies and is enhanced by the interviewees responding directly to the interviewer.\textsuperscript{20} Furthermore, what is gained in richness of context may be lost in imprecision. We began with a deliberately vague question (‘patient you like’) in order to permit GPs as much latitude as possible; and in fact, they seem to have interpreted ‘liking’ to cover everything from profound admiration to ‘a challenge successfully met’. The decision to restrict the study to trainees may mean we have offered a snapshot of an unusually reflective minority. Finally, we have applied corpus linguistic techniques to a small sample size (fewer than 50 000 words) and have therefore not depended solely on this methodology.

Findings overall seem to support calls for ‘a culture of humanism’ in medicine,\textsuperscript{21} and to invest such concepts as ‘continuity of care’ with meaning, by displaying their purpose. In addition, we suggest that the data offer a clear sense that the participating GPs have the intelligence, insight and sensibility to be touched and changed by their patients.

It is interesting that some of the GPs talked about patients who were like them in terms of educational level and social class. This fits in well with a view that, when it comes to softer areas of doctor–patient involvement such as communication, there is indeed such a preference.\textsuperscript{22}

However, many did not. Amongst the patients were many whose daily lives and, perhaps, aspirations were
apparently different, and they were possibly valued for that reason, such patients give a sense of the richness of other lives and of the possibility of human courage overcoming health problems against a background of deprivation rather than privilege. This is in part the conventional view of the educationalist that ‘learning’ is a two-way process and that teachers (or doctors) derive as much from students (or patients) as they give. And certainly, we would conclude that these narratives could provide educational and training material of exceptional quality, suitable for a wide variety of inductive (case or problem based) approaches where the thrust of the training is to develop reflective practitioners, much as O’Dowd and Wilson recommended. The trainers themselves represent excellent role models in this respect.

Conclusions
This paper aims to start a dialogue on heartlift and offers a positive approach to the doctor–patient relationship useful for reflection, teaching and training. The study shows that interviews can evoke rich narratives which provide useful material for further research. Topics might include the extent to which GPs do indeed favour patients who resemble them in social class and economic status, as well as the impact of heartlift patients on doctors and general practice. We speculate that Health Professionals unable easily to identify ‘patients they like’ may have motivation problems and need support—this is an issue which should be further researched.

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References
18 For a user’s guide and other information about the Bank of English, see: http://www.titania.bham.ac.uk/does/svenguide.html (accessed on 15 February 2007).