|  |  |  |  |
| --- | --- | --- | --- |
|  | POLE 1 | VIRTUE/THEME | POLE 2 |
| 1. (1+26) | Doctor decides/paternalist | Patient-centred/deliberative+holistic approach/ decision negotiations | Patient decides/informative |
| CH  AM | 1.Story: Patient wants doctor to decide (MC) –WX01 “99.9% would say, “what do you think I should do?”  26.Story: Doc.acts **paternalistically.**  B203: “ but sometimes you have to override what the patient wants…when.”  BX03: “ she would have gone into meltdown”.  N104: “for me it was quite comfortable to do something that is invasive…”. WX02 “but she needs it .we need to convince her… arm twisted”. NX03, WX01 WX02.  **Patient makes a medically sub optimal decision**  N501 pt refused simple procedure which meant she was discharged home under the care of the palliative care team when this could have been avoided “the best decision isn’t always what you think is the right on”  BX09 pt withheld info from Drs regarding their cancer diagnosis ‘Look, we have got a diagnosis, we are not talking about the diagnosis’.”  N202 Pt sent for brain scan to alleviate her worry “She's not got one, but she keeps coming back, so I will send her for a scan even though  she probably doesn’t have anything, but for her to see it on a piece of paper that there's nothing there will be good for her “  NX05 Colleagues who do not discuss options but state ‘Okay, you got that, you got to have chemo, that’s finished, nothing else to offer…there is a tendency for some clinicians, if the patient doesn’t pick the treatment that you recommend, they are being then treated as making the wrong decision.”  W506 pt with complications of diabetes who self discharged and whether clinicians just focussed on clinical consequences when trying to persuade him to stay  **It’s an abdication of Doctors’ responsibility**  BX03 “.. we put people and patients in a really difficult position…. Are we doing shared decision making or are we saying, “I’m offloading the responsibility to you and you make that decision? … little guidance as a junior when we discuss resus with relatives and potentially leave them feeling they have made a decision to save not save their wife  NX05 I don’t support the extreme of what we call patient choice, so we let the patient choose A or B, then I become not a professional person, because my skills and experience and knowledge is what the patient is after and I should be able to provide her the information to tell her that, ‘If you choose A, what will happen, if you choose B, what will happen’. You can’t just say, ‘You choose’. “  **Respect for autonomy – servant leadership**  B107 even if the patient themselves does not have their own best interests at heart… our role is to allow that decision to come to fruition…. we shouldn’t make decisions on their behalf unless they completely give us that power, or they are unable to make those decisions for themselves”  N201 Pt who has tried CBT , wants an alternative which GP does not think will be beneficial but continues to explore it because if pt “thinks it will make him better then there is a chance that it actually would help him, even if it is only in the short term”  **Holistic Care / Quality of Life**  N107 “where possible, we should be asking patients about what they would deem an acceptable or unacceptable quality of life, with us giving them unbiased and clear information about what is and isn’t possible. If the patient isn’t in a position to weigh that up, then it really should be us talking to family, and trying to establish what they would have wanted, but I don’t think that’s what happens, completely”  W503 young girl with cerebal palsy in ITU “we talked to her mother and she was saying that she was really happy, and although she is severely disabled and bed-bound most of the time she still enjoys her life and we can’t be the ones to judge that ever”  C section patient (BX13) | 1.Story: What is right and best for the patient? (CH)  **Communication**  26.BX02: “ constructive conversation” *where antibiotics were probably not a good idea. …. ethics probably helps is just to change the tone of the conversation…. the body language is about you’re trying to understand a problem. “We’re fine. Here’s a problem that we’ve got.”*  B207: I believe that you should strive to take into account the patient’s wishes as best as possible, whether they’re going to have advanced notices and things like that, but as long as you try your best to tailor your care around what that patient wants, or in fact doesn’t want  B102: Choice for patients : but  particularly more difficult  decisions, just talking to the  patient and trying to get to  know them a bit better and  their kind of particular outlook  which might affect their  decision to go between two  treatments of roughly equal  weight and then possibly  based on that, kind of guide  them to a decision that I think  might suit them better or just  discuss that a bit further with  them.  B102 Explain our thinking to the patient …what had changed … present the information about the resuscitation process again and try and do it in a non-biased way …. it’s not the most pleasant experience… what do you think? … give them as many of the facts as they want or as they need to help make the decision.  NX06 “So people have come in and said, “I must get to a surgeon, I’ve got this pain, I must be seen,” and I will sort of be, “Okay, look, let’s assess is this really what you need to do,” in the same way as the antibiotic conversation really. So from my point of view I will listen to what people say and what they think is going on and why they think it’s going on and I will take my own steps to evaluate and assess and ensure that what is happening is I think in the best interests of the patient  N104: “was that what that lady would have wanted”.  W108: “we need to have more of a discussion about it”.(AM)  **Time**  N108 reflections- time for relationships with patients esp important in palliative care  ***Common Sense***  *BX10 . “.I just call it common sense…. making highly complex decisions and to make them as simple as possible and as short as possible really, so that families can go away and understand that. And that's not something that everybody can do”*  N202 But it sort of comes down to just listen your patients and just treat them like an equal. Just because they don't know the medical background doesn't mean that they’re stupid or can’t understand - they just don't know “  ***Being Genuine***  *N202 .. he's very genuine… I think he really, really involves his patients in their own care, which is really important.”*  *NX06 GP with a patient with a worm: “being honest to her and saying, “This is what I think you’ve got, I’m really not quite sure…seeking advice “*  **Enabling Patient Choice**  N104 Complex pt with dementia – decision to re-insert NG feed tube without being able to be sure of patient choice  **Dr as patient “advocate” with carers**  BX12 resus of seriously ill  baby “help parents to  think about things from their baby's view “  NX04 Patient with learning disabilities “*code of practice to address the best interests of the patient, not of the carers or famil it is a collaborative way of working here*  WX06 93 year old, septic, with many relatives and other staff who wanted her to die  **Taking patients and carers concerns seriously**  N202 Explaining to relatives why a hernia repair is not necessary  NX05 Patient with cancer who is more worried about her dog *“ I am aligning her agenda to my own, I am changing my agenda to suit her”*  ***The informed patient***  *WX06 “I’d rather that people now come after having looked at the internet. If I had my way, I’d make it even near compulsory for patients who are looking for care or interaction with me, because this is very, very sensitive and precious, that they are going to interact and give me a responsibility of a health concern “* | 1.Story: Patient first (MC)  WX02: “infected obstructed kidney-but she refused….”    26. B212:”she was in pain”. BX03: “we put people in that position”. B107: “allow that decision to come to fruition”. N501: drain for feeding-she didn’t want it.(AM )  1.Story: Patient first (MC)  WX02: “infected obstructed kidney-but she refused….”  26. B212:”she was in pain”. BX03: “we put people in that position”. B107: “allow that decision to come to fruition”. N501: drain for feeding-she didn’t want it.(AM )  **Competency and Capacity**  Dr may have to decide if patient lacks these  *B203 “..temporarily incompetent, so if they’re under the influence of alcohol or they’re brain damaged, for example “*  *B109 “..so one of our middle grades just decided to put a DoLS on, so Deprivation of a Liberty, so this form was just signed, filled out in the front of their notes. There was no capacity assessment done at all. They had clearly no understanding of what a DoLS was, you can’t put a DoLS and be like we’re forcing you. I was saying to the nurses like this is great but I’m still not going to go and manhandle this guy down to the gym to do some exercise”*  **Patient Deference and the Doctor as the expert**  *BX03 “..when people are very ill and very vulnerable, they need guidance as much as shared decision making. …..they just say, “You decide doctor. You’re the doctor, that’s why I’ve come to you”.*  *W501 I hit a bit of a stumbling block when I get patients who say I don’t want to know. Which happened quite a lot in oncology…. You decide. You do it. Tell me when to turn up and I’ll turn up.. which was a bit odd for me.. I don’t want to decide on your life for you*  *N202 The older generation*  “they sort of come in and say  I'm taking all these tablets. I  don't know what they are  and why I take them, but I  take them. The doctor tells  me to. I take them”  **Witholding information from pts when is this right**  *BX03 Not discussing* Arrhythmia *with a v anxious pt “ they’d have gone into meltdown”*  **Paternalism as decisiveness**  F1s talking about respecting surgeons decisiveness  B108 “*I .. respected his decisiveness for taking a practical course of action and moving things on rather than perhaps a slightly more navel-gazing approach”*  *B112 “you have to admire them from their utter lack of care of what the patient thinks of them and they will go on regardless”.*  **Persuading pts – being blunt**  WX02 lady who had a fear of surgery and was refusing an operation on an infected obstructed kidney “ *you do feel a bit bad that you’ve twisted their arm a little..but we see the consequences of not having it “* |
| 2. (2) | Select few get treated | Justice/ Fairness | Everyone gets treated the same |
| MC | *Story:* first in (B205), age, non- smokers (B205), non-alcoholics (B208), someone you know (B106).  *Not those living alone with mental health issues (BX06)*  *social justice: older people taking up resource or people who contribute to society?(BX09).*  *IVF postcode lottery (N201?/N204)*  *Family or medical decision? (N505)* | Story: A&E examples (CH) DNR (MC) Words: Dignity, equality, prejudice  Cannot be prejudiced –against other people, (B205).  *Balancing it with fairness, justice, sensitivity, considering the person as a whole. (BX06)*  *Shared management decision*  *(NX03)*  *Let her die (W503)* | Story: Smokers (MC) GP practice charges fees to all (BX03). *Ivory tower managerial decision (W104 follow up)* |
| 3.(3) | Don’t share anything private | Confidentiality | Share everything with everyone |
| MC | Story: GP keep opinions to yourself : “ a patient’s never going to get the best diagnosis. prognose…well, best diagnosis, most accurate history if the patient tells you everything. Like you …(B201)  Senior partner and patient with heart attack (NX02)  NX02 Girl who committed suicide but mental health services would not share info with parents  **NX02 – GP practice :** Pregnant Patient, Snr partner chose not to tell her she had MS ,she had a relapse during pregnancy  **Dilemma – when one professional wants to break confidentiality but others don’t or how to**  **circumvent confidentiality for the “good of all”**  N204 Patient with HIV and how to discuss with partner | Story: HIV/ affair/ husband/wife (MC)  Story of cancer girl taken to head teacher(B208)  TB infection patient (B107)  Being a Muslim and confidentiality (B211).  **BX12** babies born as a result of abuse or a one night standard need leave those judgements and focus on optimising the care for the baby  “you have to acknowledge you  have those feelings .. have a  forum where people can express those feelings ..otherwise it flows out into gossip or unprofessionalism.  undercurrent of… Everybody has the inner turmoil because you can see everyone asking why are we doing this? “ | Gossip about a patient in a pub (B201) |
| 4.(4+16) | Ignore the legal constraints(4)+no belief in ethics(16) | Lawfulness(4)+ethics is necessary (16) | Constant litigation protection(4) +obsessed about ethics(16) |
|  | 4: Negligent practice- followed the directions of a senior doctor even though the practitioner knew he had no training to perform the clinical procedure (B501)  16: Story : Sexual health clinic, “what’s the point of consent (B501) | 4. “Yes it is going to be extremely distressing for her as well as the staff involved so that is not a decision to be taken lightly and it never is taken lightly but it is going to be interesting to be involved in that discussion process. The problem is if you don’t take her down, are we as a Trust responsible for her wellbeing if she gets ill and dies and that was caused from the self-harm so her refusing has put us in a bit of a double bind where we have to do something, we have to take a decision about what is in her best interests and yeah, obviously I recognise that is not my decision to make alone, it is the responsible clinicians and they are going to seek advice from the Trust Lawyers and from other teams” (W 108). “So, your decision - you've considered every aspect. It is useful from that point and I think maybe the legal framework is trying to help you consider everything from that point. But I do feel there is an underlying litigation - covered your back, have considered all of these points which… It's useful because obviously, it's been done for the patient's best interests but the legal underlyingness to it I feel is always prevalent.” (B111).  16: Story: “Compromise”(B112).  NX05 : three stages they went through. | 4.defensive medicine – not necessarily in patient’s best interest: So what I felt about that being an unwise decision was that I think he was trying to take the least litigious route, that “This family are going to complain afterwards and that’s going to be a pain to deal with”.(BX03) “ I think people try and brush them under the carpet a lot and the problem is in the NHS there is quite a blame culture, people are very quick to tell you if you have done something wrong, very poor to tell you if you have done something right and when something goes wrong and things weren’t quite handled correctly, people get very defensive, they try and say that things were done correctly or they try and blame somebody in particular or they just try and keep very quiet about it, because there is a lot of fear about you know losing your licence or being called up to disciplinary or, so it is very defensive a lot.(W108).  Yeah, I don’t really think you could have one without the other to be honest because… The only time where I can see it being an issue is where for example your patient is adamant that they don’t want the treatment that you think is right and then what do you do because surely like from the patient’s point of view the good doctor is someone who’s going to respect their wishes and do what they want? But then from the medical professions point of view a good doctor is someone who treats their patient and cures them, so then which type of good doctor are you going to be, you know, because that’s the only negative thing I find in the medical profession is that there is a lot of, you know, guidelines and things that you have to stick to and lots of like legal loops that you have to always be aware of. But I completely the necessity of them being put in place but I do feel as though sometimes it restricts your ability to practice like medicine (B211).  “defensive medicine …covering your back” –Wagener’s granulomatosis case (W503 is actually N503?-CW)  “8 page complaint letter- she did put up a lot of fuss and that makes people write in the notes” (BX13)  16.Story: |

|  |  |  |  |
| --- | --- | --- | --- |
|  | POLE1 | VIRTUE/THEME | POLE2 |
| 5.(5+7+8+11) | Does not seek guidance-Doctor autonomy/Guided by own experience(5)+ Making own decisions always(7)+ Just make own decisions(8)+ Opinionated/Arrogant/ always has a viewpoint(11)+no trust in others(17) | Consults others /guidance Synthesis of guidelines and experience(5)+ Obtaining senior guidance as reqd.(7)+ MDT / Team involvement (8)/obtain guidance + Being humble(11)+trust (17)+interpret guidelines contextually | Constantly seeks guidance(GMC/ NICE Guidelines scrupulously followed (5)+ Asking seniors about every decision(7)+ Whole team consulted about everything(8)/defer to others(suggested by AM/CW)+ No opinions; others know best(11) +unquestioning trust(17) |
| 5.AM  7.AM  8.MC  11 (CH) | 5.Story: PDS training (BX02)  7. Story:SHO story: “he’s very academic, he knows the guidelines for everything off by heart but he doesn’t really have a grasp of the fact that not every patient can be treated as per guidelines… And so we’ve been working with him to try and get that across and he’s had real issues with not calling for senior support because he feels that he’s got a guideline to follow and that he follows it.(WX05)  N104=“well you have to do it”  8. Story; ‘You can’t defer your decision through [MDT] communication if you believe it is the right one’ (B201); ‘Personality / values of consultant / MDT may differ (liberal v. conservative), or rely on previous experience’ (B201); ‘Responsibility important in decision-making; buck stops with the doctor’ (B201)  11.Story: Story: Certain consultants like this (?)’forceful manner’-‘my way or the highway’(B107) | 5. Story: ‘I like his decisiveness’ (B108 –node: attributes of a good doc.).  7.Story: I talk to my Dad (MC)  Story: from someone a bit more senior would probably be the most important thing for me (B102).  Chlamydia-+Coil story (BX03)  Escalate (BX01).  8.Story: MDT ethically important (MC)  ‘Involving MDT is a good idea, but could easily alter your subjective ethical decision-making’ (B201); ‘Wise decision could involve weighing up what everyone has told you [about the patient]’ (B201); ‘Wider experience of MDT / seniors gives useful alternative views’ (B202); ‘Nurses lack the clinical knowledge of doctors and make lesser decisions, but can bring a more personal element to the medical / family interface’ (B202); ‘One day a student, next a doctor with ↑responsibility; rely on others to ‘get you through’’ (B202); our role in terms of kind of updating the senior doctors as to the progress of the patient throughout (B102).: ‘Stick two fingers up to it [MDT / GMC opinion etc.) and listen to what the patient wants’ (B201)  11. story: | 5. Story:“ young doctors only want to follow guidelines”(WX05),” you’ll, kind of, defer to people with more experience, for their opinion.. as a, sort of, junior level doctor. But, you know, bigger decisions, you’re not going want to take that onto yourself, you’re going to defer to people that have got the experience. Yeah, and then, like, NICE guidelines and so on”(W203)  7. Story: ’safety net’ (B106) or  “often if you’re working out of hours, unless someone looks like they’re going to die immediately, no one wants to make a decision, and so they defer it, and so you just carry on aggressively managing patients which I’ve seen occasions where I think that that was inappropriate” (B107),  8. Story: Treat all team the same always (MC)  ‘You refer more stuff to your senior,and you check guidelines more frequently because you don’t want to get it wrong’ (N107 followup)  11. Story: |
| 6. (9). | Use own values and belief system (9)+sticks to own moral code despite context(23) | Taking values and belief systems into account(patients and doctors) (9)+ willingness to stick to own moral code(23) | Go with the patient’s values and beliefs only (9) +easily swayed to override own moral code –depending on contextual factors (23) |
| MC | Story: Base ethics on own upbringing:cannulation and F1 (B501) Use own Christian beliefs and values (NX01) Go with my gut feel (W106)  *It’s about my personal beliefs – we can’t avoid that (W508)* | Story: MH patient certified (MC) Jehova’s witness (B110) Kidney transplant (B211) Patient and family values and beliefs and nursing staff in the case of the dialysis decision (BX01) Not following own emotions (BX02) Capacity assessment – wise is better than using own values (W202),”an understanding of how different people live” (B110=node: attributes of a good doc.) “let him go in peace as he wanted”(WX04).  *Use colleagues to decide how we approach things from cultural*  *differences and religious differences (BX10).*  *Religion and medicine (W103 Reflections)*  *Taking the patient’s belief’s into account and working out a solution with the MDT that meets those (W504).*  *“I won’t ever, ever judge somebody that has taken his or her own life, especially if they’re in despair or if it’s in that situation because we cannot judge them. But at the same time, I don’t think that we should be the ones, as doctors, fulfilling that wish,” (WX04).* | Story: Patient as a free rational agent to commit suicide (MC).  *Family religious belief of life at all costs (BX08)*  *Patient wanted one particular treatment (N201)*  *Spiritual belief that you exhaust every last option (N507)* |
| 7. (12+13+20+  27) | Stay removed(12)+Aloof(13)+Crying at everything (20)+too distant (27) Spock like rationalist | Being genuine(12)+Interpersonal communication / relationship building(13)+Emotional intelligence(20)+empathy(27) | Share everything about self(12)+Too chatty (13)+. Too involved/not objective (27) |
| 12.MC  13.AM  20.MC  27 AM | 12.Story:  13.Story: N501:”So it’s sort of like eight people follow a consultant around.”  W507=at 0:10;29 sec-“questions unanswered”.  “de de de…”(B205- node: attribute of a good doc.).  B108: “grouchy and combative…a sort of surgical stereotype”.  *Alternatively* -: “ he treated the problem so treating them nicely became less of a big deal”(B112).  “ignore them, just assume…(W103),referred to patients as ‘bed whatever’ (B107-node: attributes of a good doc.)  20. Story: early career FY1  27. Story: docs follow senior surgeon wearing suits and ties (N501-node: aloof) | 12.Story: getting onto a personal level with patients (B106), Treating patients as another human being”(B109- node: attributes of a good doc.)  13. Story: Patients feel better (MC)try to empathise with why they they’re feeling that way… (NX03).  “So then that helps and I think that for a lot of medical decisions, if you haven’t done an internal journey, you haven’t grown in a lot of different aspects, then when you get to that point you could become either paternalistic or not interested or too technical” (WX04).  N107: younger doctors’ .and that was very impressive..”  N202:Good GP tutor and her own GP.  “what if my grandad, my relative in hosp. how would I want the doc.looking after them”(W103)  “to get onto a personal level” (B106),  “ He was not dogmatic” (; seek opinions” (BX03-node: attributes of a good doc.),  “bed whatever…focussed on their social …”( B107-node: attributes of a good doc.)  20. Story: “But the doc. Knew that the pt. was aware” (B204-node: attributes of a good doc.)  27. Story: “somebody who is caring and empathic (NX01, node: attributes of a good doc.), “keeping family well informed and explaining…plan A, Plan B ….(N101 –node: attributes of a good doc.) | 12.Story: senior sharing his sex life.  13. story:  20. story:  27: story: “ there was a DNAR in place. But then some more members of the family arrived, spoke to the consultant. He then overrode that and put that she was for resuscitation. Because what they wanted was that if she were to arrest they wanted her to be resuscitated and kept on ITU until all the family could arrive and say goodbye to her and then we could switch everything off” … “He also actually was going through something himself with a family member who was terminally ill, and I think that probably coloured it as well” BX03 |
| 8 (18) | No consideration of finite resources and budgets(18) | Resource/cost awareness(18) | Obsessed with cost and resource limitations(18) |
| AM | Story: “The outcome was never going to be good. Resource wise, people shouldn’t go on to ITU for that reason”(BX03- node: futile t/m).  “whatever just to make the patient comfortable”(N101-node: resources.) | Story:N202 ‘patient with headache insisting on ca.and wants a scan-GP story.  BX04: “not to waste” heart transplant allocation. | Story: NX04 “computer shows cheaper version of medicine” |
| 9 (21) | Knowing no limits (21) | Knowing your limits/risks?(21) | Everything is a limit (21) |
| MC |  | Story: a good way to sleep at night is to know your limits. “aware of their own faults ,taking a step back”(node : attributes of a good doc.(AM- B111).  knowing your own limitations,(W108) |  |
| 10 (15+25.) | Treat at all cost+ avoiding the issue (15) | Recognize futility/ease of passing +difficult conversations (15) | Withhold t/m without due process /not discuss all t/m options |
| AM | Story: The Muslim perspective is a more vitalist perspective in terms of – you can do everything that’s possible. Whereas I think there’s – generally there’s mistrust of the NHS that we pull out too soon and we don’t do everything that’s possible and we don’t do everything we should be doing etc. etc. but that’s compounded by an ethical – a sort of a cultural view of life I think. … people who are not willing to accept that there’s an end to things, so it’s not purely around ethnicity.(BX05)  N103 =Dementia pt.  the lady who should not have had a hip re-op.(BX07).  I hold medical and the role it plays in treating disease in extremely high regard, I could not work as doctor if I did not.(N108,W103)  Talking about another scenario on the ward –neurologist has been very upbeat about “I can treat this”but this has been going on for a very very long time” (BX05).  Many of my colleagues -Avoiding the issue as it may be emotionally consuming: “The easiest route will have been just doing the scan, passing the patient on to the gastroenterologist and oncologist and making the decision” (WX04). | BX05 : biopsychsocial model  WX04: we will do what is  B107: “allowed to ease out the rest of their life”  BX03: “Hospice jobs”(node: futility)  W202: “any remorse in putting them on an end of life”.  W501:”extubating and stuff he didn’t breathe at all”, “if he didn’t have other comorbidities…”  Brain compression patient : And we’d probably never have been able to get him to the point that he could have gone back to his own home, or indeed, even a residential home; and so we made the decision at that point to withdraw treatment, and to let him die naturally, and I felt like that second decision was the right decision for him, even if it was ethically challenging - and what I’m not sure of, is that in hindsight, the initial decision to operate on this man wasn’t the right one. (N107 (follow-up)  15: patient with Ca.spine(?) not sugar coated(B106)+ difficult conversations lead to decisions (BX03) Grumpy God of Medicine(WX01)  we try and balance in our minds every day, where do we draw the line? Where is actually the appropriate level of care to go up to ? (NX03)  say to the cardiologist: “actually, we are stopping some of your medication (BX05). See the limitations of their treatment (BX05).  “just through the conversation get to the point that he is aware that he has a cancer and that he doesn’t want to be investigated as he said two years ago. So I discussed with him and say, “Okay so I’m going to cancel the scan; there’s no point in doing a scan because we know that what is happening to you” (WX04) | Story: therefore his quality of life wasn’t as good, and that we shouldn’t necessarily, inherently escalate his care… I don’t think it would have, because his pneumonia was really severe, but I feel like the information we gathered about things wasn’t fair, - t/m, biased (N107 followup).  Amputation case (B102)  The patient did say that they felt that not all options were discussed at that opportunity(NX03)  15: You are probably going to die in hospital…but did not want to tell you yesterday because it was your birthday (B205)  “the neurologist says they’re going to get better; you say you can’t make them better”(BX05) |
| 11 (6+10+14) | All the time in the world(6)+Self-care comes first(10) | Time for patients/understanding( 6) +self-care and patient –care(10) | Too busy to understand (6)/too busy for any of these +patient care comes first(10)+Follow a strict process of reflection(14) |
| 6  14. | Story: “now you can’t be completely self –sacrificial…as long as I have done my best ….because otherwise you burn out” (BX03) | Story: sphere of influence/altruism (CH)+Cardiac infection story (MC)+”they’re kind of going the extra mile”(B103 /AM)+”sit down with the patient and listen to what they say(B107/AM)+ sit down and talk to patient “how can I help you”, “what is important to you”(with learning difficulties?) (WX04/AM)  “and immediately it was panic and my thoughts were all over the place. I couldn’t process anything. I got so far as to finding the guidelines online for hyperkalaemia to treat the patient and…”(W106)  14. story: “ I have a very reflective learning”. One of the things that I think that happens to the juniors that become seniors with this kind of ability of doing decisions based not only on knowledge or on guidelines, is that you do an internal journey and you accept a lot of different things…. I am good at doing the end of life care and I’m good communicating bad news to the patients because I have accepted my own situations and suffering if I was in those situations. So what I have done is – I have already reflected and prepared myself and experiences –experiences tach you a lot… For example I can tell I have accepted my own mortality for example and I have accepted that I will become sick at some point. So I have accepted the natural cycle.(Wx04)“ because I have already done that internal journey, that is what makes me quite good at facing and counselling other people and that are dying or are having a severe illness as a doctor, because as a human being I have already done that internal journey. So then that helps and I think that for a lot of medical decisions, if you haven’t done an internal journey, you haven’t grown in a lot of different aspects, then when you get to that point you could become either paternalistic or not interested or too technical” (WX04/AM) |  |
| 12 (17+22) | No interest in mentorship(17)+Negative role model(22)+ support for ethical DM (senior guidance) | Mentorship/Willingness to be approached by juniors(17)+Role model / | Constant contact/guides juniors(17)+desires emulation (22) |
|  | Story: “should be looking up to my consultant”(B107)+  “I didn’t like the way he personally handled it and it kind of made me feel a bit like everything else he’s done I was a bit like, ‘Oh I’m not sure.’ Like it made me question him a bit more. Whereas if it was someone who’d been really lovely I’d probably have a bit more respect and have more time to listen to what they said….That’s one of my biggest things that I absolutely hate is when doctors … Like they’ll go in, pick up a chart, talk to other doctors, and they don’t say, ‘Thank you,’ to the patient or like, ‘How are you?’ Because they’re in bed and they can’t get out and you’re just like, ‘Come on, be nice.’” (B205) | Story: “excellent, excellent consultants…instil in my practice (B202/AM)+more experience, draw on best bits (B202). Use of haloperidol in Parkinson’s disease (B107)+ Story : DNAR conversation –the vast majority said” absolutely not(B107). “Actually I can think of a couple of people who just, you sort of look at them and you’re like, ‘I want to be like you,’ because they make you just see that they’ll tell you why they’ve made the decision that they’ve made, they’ll work through problems and they’ll make a point of saying to you, this is an ethical thing, not just a medical thing. And they’ll tell you and you’ll think, ‘Oh god, I hadn’t even thought of that.’ But they also really, really know their stuff as well, so it’s not just …(N501) |  |
| 13 (24) | Decisions are only ethical (24)/arts/humanities only | Decisions are both ethical and technical – reflective equilibrium/synthesis of science (tech.skills) and art (human compassion/Holistic | Decisions are only clinical /technical/scientific |
|  | Story: There is a definite end result that cannot be changed and you cannot go back on. So, the resuscitation order, once it’s been put in place and they're gone, they're gone. There's no, 'Oh, we’ll just change the antibiotic'. And also, it has a bigger impact on the family and the relatives as well. So, I’d say it directs finite, end result with a large impact on the family and the patient themselves.(B111)And the GP handled it so well, it was unbelievable. He didn’t hesitate, he knew the right questions to ask the relative first . There’s always that tendency of it getting too clinical and like you kind of forget that you’re actually dealing with a patient.(B111) | Story: “So I think the doctors that you really admire are the ones that talk you through the ethical decisions, but are also really good at what they are doing, you can tell they’re really good at what they do. But I think in a way the two go hand in hand (N501).  “I think they need knowledge of the situation from numerous sources, so there is no point having knowledge from a medical source if you ignore all of the social sources or another input. It is the ability to gather process and then go and actually make a decision yourself about it.(B106)  Biopsychosocial spiritual model (BX06)  Biopsychosicial/ holistic assessment of patient (BX05),  Psychomotional (WX04)  And taking into account their social circumstances as well. Yeah, so that is quite a holistic approach to dealing with the patients(N101) | Story:WX04 (simple cases vs complex cases)  Patient with urinary retention –pass a catheter (N507)  Junior follows protocol and gives amitriptyline for neuropathic pain – urinary retention (BX05) |
| 14 | Never bother to reflect/analyse or share learning | Event analysis/reflective/shared learning | Over analysis/Navel gazing/not confident to make a decision /overcautious /defer |
|  | “I think it’s a bad doctor that goes and makes rash decisions and is very confident about what they are doing”…dubious decisions…. (W108) | Significant event analysis(NX03),  “but I’m good at it and my colleagues will say that. I am good at doing the end of life care and I’m good communicating bad news to the patients because I have accepted my own situations and suffering if I was in those situations” (WX04?) | “peers, that they have become a massive amount of knowledge but no decision making. Because they have so many differentials, so many doubts when they see a patient, that they don’t get to any practical decision …you don’t have a decision” also at (0:46:41)(WX04).  “I think having that sense of doubt, I think I have more of it than most” (W108) |
| 15 | Cowardice/ignore | Courage /confidence to speak out/whistle blowing | Foolhardy/be a nuisance |
|  |  | Make tough decisions (BX06) | Consultant would not listen to anyone –not even the family –wanted IV line set up and then when had to do it themselves –realized the mistake and withdrew (W101FP) |
| 16 |  | Trust/trustworthiness/integrity\*as subnode) |  |
|  |  | Wisdom must be underpinned by a high level of integrity (BX06)  I think integrity, I think that’s really important actually.(B109)  My consultant at the moment is really good and he’s very good at communicating with the patients and they all love him. He’s very authoritative, people trust him.(W201) |  |
| 17 | Defensive, investigating everything | Resilience | Seeing the patient as a nuisance and avoiding them. |
|  | Repercussions , including complaints, can be very detrimental on your well-being as well…so may be doctors will be more defensive in terms of investigating more( NX03) | Cancer patient whose family refused withdrawal – doctor had to act as the ‘the bad cop’( - we were all in agreement, here is the line, we are not talking about that anymore, now let’s move to the next step.(BX09)  92/93 year old patient with pneumonia whose family wanted no treatment—but treatment was given and the patient recovered(WX06).  “but sometimes they are pulling in different directions and of the directions, I always go first for the patient and I have always gone first for the patient. And I know that that is the kind of thing that everyone says in medicine, but in my case, I have sacrificed and I have sometimes – do brave decisions facing risk and facing disagreement of different structures, organisations or colleagues” (WX04). | Many of my colleagues - Avoiding the issue as it may be emotionally consuming: “The easiest route will have been just doing the scan, passing the patient on to the gastroenterologist and oncologist and making the decision” (WX04).  “Anyway this thing happens, that happens and he goes home. In the morning the consultant in A&E says, “Can I just give you a patient who is a pain in my backside and will you take a look?” and I said, “Okay fine”.(WX06)  “am I thinking clearly now? Do I need someone else to take over ?that person is driving me insane” (WX01) |
| 18 |  | Experience and wise decision/practical wisdom |  |
|  |  | Story: One example is, suppose a 67-year-old patient gets referred to us for transplant. Generally, in our minds, 65 is the cut-off for getting a transplant, but if the person is fit, looks biologically younger, then you may say, “Well, this patient may be able to survive this operation, so let’s take him”. (BX04)  There’s always going to be unlicensed use. But there is more practical wisdom, risk or whatever you want to call it, about using unlicensed things. –example of Amitriptyline (BX05)  I think as a bare minimum you have to think, you know, am I confident that I’ve made the right diagnosis, that I know what I’m treating, I know what the guidance for treatment of that is and I know enough about the patient to know whether or not I stick to standard guidelines or is there any reason to deteriorate from them? (WX05) |  |
| 19 | Never asking for second opinion | Open to Second opinion | Always ask for second opinion |
|  | Story:as doctors ”we fight each other too much”-we all have different criteria,..(WX04) .  Patient with spasticity – surgery –followed by impairment problem (BX05)  Patient with spasticiy and surgeon operates (BX05) | Ask others – (WFY2-05)  Discussion , quite often the medical speciality …in the discussion….come up with a global agreement (BX09) | Story: “GPs are very afraid of making these decisions” (WX04) |

Original numbers in parenthesis and the new number highlighted.