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Understanding Physicians' Challenges When Treating Type 2 Diabetic Patients' Social and Emotional Difficulties

A qualitative study

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OBJECTIVE—To explore physicians' awareness of and responses to type 2 diabetic patients' social and emotional difficulties.

RESEARCH DESIGN AND METHODS—We conducted semistructured interviews with 19 physicians. Interviews were transcribed, coded, and analyzed using thematic analysis.

RESULTS—Three themes emerged: *1*) physicians' awareness of patients' social and emotional difficulties: physicians recognized the frequency and seriousness of patients' social and emotional difficulties; 2) physicians' responses to patients' social and emotional difficulties: many reported that intervening with these difficulties was challenging with few treatment options beyond making referrals, individualizing care, and recommending more frequent follow-up visits; and *3*) the impact of patients' social and emotional difficulties on physicians: few available patient treatment options, time constraints, and a perceived lack of psychological expertise contributed to physicians' feeling frustrated, inadequate, and overwhelmed.

CONCLUSIONS—Recognition and understanding of physicians' challenges when treating diabetes patients' social and emotional difficulties are important for developing programmatic interventions.

A recent study reported physicians' awareness of diabetic patients' social and emotional difficulties (1,2); however, whether physicians can integrate this information into their clinical practice is not known. Diabetic patients experience disproportionately high rates of social and emotional difficulties (3–8), which are associated with poor glycemic control (9) and may interfere with the performance of self-care behaviors (10,11). Understanding how physicians perceive the severity and consequences of patients' social and emotional difficulties is important for developing solutions for these problems. We explored physicians' awareness of and responses to social and emotional difficulties in type 2 diabetic patients.

RESEARCH DESIGN AND METHODS

We used purposive sampling (12) to interview English-speaking endocrinologists and primary care physicians with at least 5% of their practice consisting of type 2 diabetic patients. We recruited physicians from the greater Boston area. The Joslin Diabetes Center Committee on Human Subjects approved the research protocol, and all physicians provided informed written consent.

We devised a structured interview guide and field-tested it for flow and clarity of the questions. Interviews lasted 30–60 min and were digitally audio-recorded and transcribed.

We performed content analysis (12) by categorizing key words and phrases to identify themes using NVivo 8 (13). This process continued until data saturation was reached. To support credibility/validity and dependability/reliability of the data, we triangulated data sources, methods, and investigators and tracked the decision-making process.

RESULTS

Nineteen physicians (Table 1) participated. Transcript identifiers (identification number, sex) are included with quotations. Qualitative analysis revealed three themes.

Physicians' awareness of patients' emotional difficulties

Physicians acknowledged how the challenges of following multiple self-care recommendations contributed to new or existing emotional difficulties:

> "Diabetes carries a significant amount of emotional baggage. . .the work involved, limitations. . .or perceived limitations on their life, or downright fear about the consequences of the disease. . .can really be a tipping point for them. I feel bad for them" (Physician102M).

They also recognized the frequency of social difficulties:

> "Sometimes they have other things that are higher priority. . .family, sick husbands, work, or school. Some patients have multiple jobs, they have financial issues. . .they just can't check their sugars" (Physician115F).

Some physicians reported trouble detecting patients' difficulties:

> "It's usually something that I don't think I always pick up on" (Physician100M).

Furthermore, physicians expressed uncertainty about how or whether they should assess patients' difficulties:

> "Every single person that I see has a whole lot more to them than I see. And how do you

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Table 1—*Demographic characteristics of physicians*

	Means ± SD (n = 19)	Range
Age (years)	48.2 ± 9.3	37–63
Years in medical practice	20.8 ± 10.1	7–34
Percentage of practice with type 2 diabetes	52.4 ± 25.2	7.5–95
Female (%; n = 8)	42.1	
Non-Hispanic white (%; n = 15)	78.9	
Endocrinologist (%; n = 14)	73.7	

bring it out? And do you necessarily have to bring it out? And would it be better if I did? These are questions I don't know" (Physician107F).

Physicians' responses to patients' emotional difficulties

Physicians reported few treatment options for patients with social and emotional difficulties. Most described making referrals to mental health professionals; however, some remarked that not all patients were open to referrals:

> "[I] try to find a way to deal with it in a medical visit and direct them to appropriate treatment, which is hard because there's often resistance to that" (Physician104F).

Furthermore, physicians noted limitations within their referral system:

> "I think it's somewhat harder to find therapists. . .I don't know what to tell someone who is [outside the city]. I know there must be people within ten miles, but I'm stuck and we don't have a good identification system" (Physician108M)

Physicians also suggested individualizing care and requesting more frequent follow-up visits:

> "For some people it totally shuts them down and they're immobilized. . .I try to understand that and then I tailor my approach so that I don't overwhelm somebody because I think that's the best way to be effective in getting their A1C better" (Physician114M).

The impact of patients' emotional difficulties on physicians

Treating patients with social and emotional difficulties appeared to take a toll on the physicians. Physicians commented on the stress and anxiety of struggling to adhere to the time constraints of a standard medical visit:

> "Well it affects me in terms of time. Our appointments. . .are twenty minutes. . .If they go over. . .you get anxious because you want to cover everything. . .You have to examine the patient. You have to order the labs. So definitely it creates a lot of stress and anxiety on my part" (Physician113F).

Physicians also described feeling tired and overwhelmed:

> "When I have people come in, I try to deal with emotions but it may make me tired. . .overwhelmed. . .I think dealing with the emotions is important but it's probably one of the more. . .frustrating and exhausting things that we do" (Physicians112F).

Some physicians felt they lacked the expertise to best support their patients:

> "I feel inadequate sometimes because I don't have enough of a background to help them" (Physician100M).

Several considered receiving additional training in psychology:

> "I even thought semi-seriously of taking some time off and doing a psychology residency" (Physician108M).

CONCLUSIONS—In our study, physicians recognized the frequency and seriousness of social and emotional difficulties in diabetes care. Many reported that intervening with these difficulties was challenging. Limited patient treatment options, time constraints, and a perceived lack of psychological expertise contributed to physicians' feeling frustrated, inadequate, and overwhelmed. The emotional toll from treating patients with social and emotional difficulties may put physicians at further risk for burnout (14,15).

Similar to our study, the Diabetes Attitudes, Wishes, and Needs (DAWN) study found that physicians recognized that a majority of their diabetes patients had psychosocial problems (1). These physicians also reported a lack of expertise in their abilities to identify and evaluate patients' psychosocial problems and/or provide needed support (1). These findings, along with ours, highlight the extent of the challenges physicians face in treating diabetic patients with social and emotional difficulties.

In conclusion, recognizing and understanding physicians' challenges are important as a first step for developing programmatic interventions. The development and testing of efficient, brief interventions that physicians can use are necessary but should not replace mental health referrals. Furthermore, medical education and training should address psychosocial difficulties that frequently occur in patients with chronic illnesses. Finally, given the brevity of treatment visits and the amount of medical information that needs to be addressed, physicians may benefit from a multidisciplinary team approach where other team members complement care by supplying assessment and treatment for patients' social and emotional difficulties.

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