Title
"It's What's Behind The Mask": psychological diversity in compassionate patient care.

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The Francis Report detailing failures of care at one NHS Trust in 2010 illustrated graphically the impact of suffering which goes unrecognised or unacknowledged.[1] The report contains many references to an increased focus on compassionate patient care and although radiography was amongst several health professions which escaped the attention of the report's authors, it is still the case that the profession takes seriously its responsibility to set and maintain high standards of professional practice in order to ensure a '*safe and fair environment*' for both imaging professionals and their patients.[2–6] The UK SoR's Code of Professional Conduct contains the following statements with regard to diversity:

1.2. You must practise in an anti-discriminatory manner, giving compassionate care that takes account of socio-cultural differences and ensuring that children, the elderly and other vulnerable groups are protected.

1.3. You must listen to and respect the wishes of patients, seeking to empower them to make decisions about their care and treatment.[4]

The supplementary notes draw attention to the need for an awareness and understanding of some of the individual differences that may not be apparent when imaging a patient:

"You must be aware of the potential impact of different values and beliefs on the way that you practise ... Similarly, you need to be aware that vulnerable groups … need additional consideration"

The statements and guidance tend to focus on the more familiar socio-cultural differences highlighted previously and, in grouping patients along these lines, overlooks the possibility that patients differ in terms of individual psychological characteristics such as emotions, perceptions, attitudes and expectations regarding their care. The 'vulnerable groups' mentioned in the guidance notes are again defined in sociological terms such as age and disability, however it is argued that vulnerability is a state not necessarily confined to certain groups, but that individual patients are all to a greater or lesser extent in a state of vulnerability due for example to illness, injury, pain, fear or anxiety. The findings from this research suggest the creation of new lines along which diversity can be drawn in the effort to meet radiographers' ongoing responsibilities to

understand, value and respect differences as part of caring compassionately for, and treating equitably, their patients.

Literature Review

For the NHS, "*advancing equality and diversity is central to how we conduct our business as an organisation"* and diversity "*is about recognising and valuing difference in its broadest sense*".[7] In the radiography literature, diversity has been discussed in terms of socio-cultural differences such as ethnicity, gender, disability and sexual orientation[8–10] and has tended to focus on important issues around discrimination and inequalities. Whilst these are perhaps the more familiar and recognisable lines along which individuals differ, and acknowledging the value and significance of the work being conducted in these arenas, it is suggested that psychological differences are also worthy of consideration. A study exploring patients' experiences in diagnostic imaging revealed themes including communication, emotions, attitudes and relationships[11] with the analysis suggesting that the relationship between radiographer and patient is not the straightforward transaction that might first appear. The interviews revealed powerful feelings and emotions and variations in attitudes and expectations in patients, none of which are necessarily visible or perceptible, especially to a busy radiographer with a heavy caseload. Some patients were struggling with feelings of fear or anxiety, or suffering the psychological pain of grief and loss; not necessarily of another person, but of a lifestyle, dream, ambition or hope for the future. Some also believed that these feelings should not be displayed, sometimes substituting what they believed to be inappropriate feelings with what they considered more acceptable ones, thereby disguising or concealing their suffering from view. The study did not address the implications of this or how it might impact on compassionate patient care.

The radiography literature thus far suggests that diversity and equity are essential matters that deserve and are receiving attention. However in order to clarify the Society of Radiographers requirements regarding the professional conduct of its members in this domain, this study explored issues around diversity and difference in its broadest sense to include psychological differences such as values, attitudes, feelings and emotions in patients presenting for diagnostic imaging. Its aim was to explore the perceptions of

patients regarding their feelings and what they valued as important in their interactions with radiographers during projection radiography examinations. The findings presented in this paper form part of a doctoral research project into compassionate patient care in medical imaging; here we report the methodology and some of the findings from the study which we suggest are of interest in deepening understanding of, and promoting diversity, and offer suggestions for education, practice and future research.

Methodology and methods

This qualitative research project was conducted from an interpretivist position which views compassionate care as idiosyncratic, contextual and dependent on social, physical, and psychological factors.[12] A constructivist research paradigm was chosen, in which researcher as well as participants interpret and construct meaning, and in which the data and their analysis are themselves social constructions. The analysis was informed theoretically by symbolic interactionism in which participants are individuals in a social world and active agents of their own interpretations.[13–15] Figure 1 summarises this.

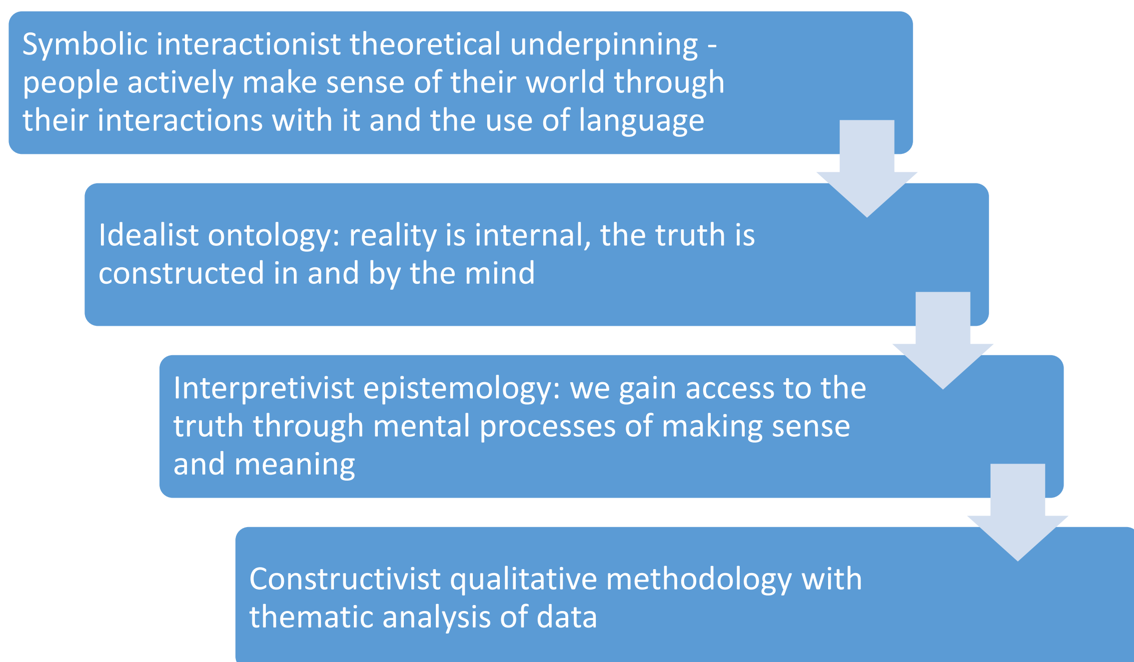

Figure 1: Graphic illustration of the constructivist research paradigm

Ethical approval from the university's ethics committee was granted with participants' confidentiality, psychological safety and wellbeing considered of paramount importance. Sampling for the interviews was purposive[16] and adult

participants ranging in age from their mid-twenties to mid-seventies from the south-west of England who had undergone diagnostic projection imaging ('plain film' radiography) from an in- or out-patient, GP or Emergency Department referral in the last two years were recruited via posters, email and social media. Whilst a lack of memory impairment was essential, detailed recollection of context-free facts lying in semantic or short-term memory was not necessary for this research; when conducted from within a constructivist paradigm, interest lies in the life events of personal significance to the participants, a function of autobiographical episodic memory in which top-down schemata interact with bottom up episodic memories.[17,18] The research also utilised Brown and Kulik's notion of the 'flashbulb memory'; selective preservation of episodes and events, often with vivid and quite detailed recall due to affective or emotional processes in combination with cognitive ones.[19] In qualitative research the necessary number of participants is determined by a judgement that adding more data is offering nothing new to the research question. Termed saturation, even this is an imprecise science; Hennink et al suggest that merely deciding that a researcher has "heard it all" is inadequate when the aim is to develop a richer, more interpretive analysis, one in which the researcher has "understood it all."[20] Over a period of four months, thirty-four one hour-long semi-structured interviews were conducted on a one-to-one basis in person between researcher and participant with set questions accompanied by prompts to trigger further discussion when appropriate. Interviews were fully transcribed and are undergoing in-depth thematic analysis.[21] This began with familiarisation with the transcripts, followed by systematic coding, supplemented with memos and notes. Participants were invited to review the transcripts and if desired, to meet and discuss the findings. Presented here are developing themes relevant to diversity supported by quotes from the participant data.

Findings

Four themes and sub-themes focusing on diversity are presented with supporting data from the patient interviews. Themes are arranged in the following four tables, each of which is accompanied by an exploration and analysis of the relationships between data and themes. Table 1 summarises themes around feelings and emotional vulnerability, and table 2 illustrates how this presents challenges in caring for patients with these feelings and emotions

not necessarily apparent to the radiographer. Tables 3 and 4 then explore how radiographers could or do respond to this diversity.

Table 1: Themes around feelings and vulnerability

Theme	Sub-theme	Supporting quotes from the data
Feelings	Vulnerability Anxiety Psychological pain	"*My worst feeling when I went to the hospital was when I had to sit in a little waiting room. It was a very small waiting room and there was a lot of people in there and I found a chair and sat down and I felt very childlike. Does that make sense?*" (patient interview 29) *"…people who are more vulnerable. I mean, people come along, don't they, to x-rays from… who are being pushed along in beds or in wheelchairs…"* (patient interview 33) "*and it's…yes, those gowns are pretty minimal, well, they're not, they're decent, you're decent but they are quite… in the middle of winter, they are quite thin, and I'm not…a fragile person really, so it wasn't a big deal for me but I imagine it might be for somebody…*" (patient interview 33)

Whilst people are not defined by their feelings and emotions, it is possible to group their responses as shown in the examples in table 1. The data illustrate only a few of the feelings and emotions patients experienced, but the fact that some of these encounters had taken place many months previously is indicative of the lasting impressions left long after the radiographic encounter has ended. The data suggest that the vulnerability mentioned in the SoR's Code of Conduct[4] is not confined to groups such as the elderly and very young or the disabled. The patients who articulated their feelings of vulnerability, anxiety or discomfort when asked at interview appeared to the researcher as otherwise able-bodied and did not fall within a particular age range or gender and it seems

unlikely that these feelings were manifest at the time of imaging. Even if they were, there is a distinct possibility that a busy radiographer, despite their best intentions might not notice, or worse, perceive a patient as “difficult” or “problematic” thereby missing the opportunity to appreciate, understand and adapt their care.

Table 2: Themes around hidden emotions

Emotional states which may be hidden from view	Unconscious or unintentional	*“I think they should realise you’re anxious so put you at ease. I think that’s mostly, that’s probably one of the most important things is to make you feel that everything’s ok...”* (Patient interview 5) *“it wasn’t the x-ray I was necessarily worried about, it was the underlying reason I was there”* (patient interview 7) *“you don’t want a fuss, so you quite often… yes, I have laid there in the most uncomfortable position sometimes, not wanting to say, ‘have you got a pillow or two?”* (patient interview 10)
	Conscious or deliberate	*“…the face behind… it’s what’s behind the mask that you’ve got to break out. So, distress, yes, but it’s never always apparent so, therefore, I wouldn’t blame anybody for not recognising the symptoms”* (patient interview 25).

The themes in table 2 illustrate how some patients’ feelings and emotions can be hidden from view either deliberately or unintentionally. Reasons for this are complex and may include a desire to co-operate in order to expedite the procedure, conformity or obedience to an authoritative figure in a white uniform, or an internalised set of rules regarding socially acceptable behaviour. Hidden from view are not only feelings and emotions but also their intensity, revealed in

the choice of language used by some participants. Adjectives such as "fantastic", "massive" and "huge" reflected the enormity of some positive experiences while "terrified" and "assaulted" echoed the strength of negative feelings amongst participants. Also not communicated to the radiographer can be characteristics such as curiosity and interest which remain latent if there is a perception, say in a busy department that questions are not welcome. Patients want or even expect their radiographer to appreciate, understand and give consideration to all of these based on little or no information or overt behaviours. This claim is illustrated and supported by data in table 3.

Table 3: Themes around professionalism and valued qualities

Professionalism Valued qualities	Empathy Understanding Kindness Awareness Consideration Concern Listening	"*you want someone that's not necessarily been through the same thing as you but that gives the impression that they understand what you're going through even if they actually don't*" (Patient interview 06) *"She was very friendly, very friendly, quite relaxing …and there was, you don't feel uncomfortable."* (patient interview 04) *…the staff are sweating buckets and they've got the air conditioning up high so some consideration for a 'are you warm enough, do you need a…do you want a blanket round your shoulders?' or…just like that.* (patient interview 10) *...I feel sometimes radiographers don't always have…I'm not saying they don't listen, I don't think they've got time to listen. …not just radiographers … others don't always listen to patients or they listen but they don't hear what they're saying…* (patient interview 25)

The theme of professionalism requires further exploration as patients express diversity not only in terms of their feelings and emotions, but also in their attitudes, beliefs and opinions when asked about the qualities they valued; some of which, technical competence for example, are included in their conceptualisation of professionalism whereas others are not. The data suggest that patients want to feel cared for and about throughout their examination despite not vocalising their concerns or discomfort. Where the experience was positive, patients described how the radiographer appeared to understand how they were feeling, appreciated some of their difficulties and wanted to help alleviate their suffering, whether physical or emotional. How and even whether these valued qualities can be cultivated is a challenge to radiography education and professional development; the final table of themes and sub-themes presented here offer some possibilities to addressing this challenge, summarised as communication.

Table 4: Themes around communication

Communication	Introductions Explanations Giving information in allaying fears and worries	*"… well, introduce themselves, even just a nice 'hello', just, I'm not, 'cos I'm...names go in one ear and out the other to me unless they've got a badge on."* (patient interview 28) *"I just wanted the peace of mind that…I wanted to know what was going on"* (Patient interview 22) *"…'cos I'm an inquisitive creature, I would have quite liked to have seen the picture that they had at the end but I…you don't get offered that, I know."* (patient interview 33)

Communication consists of both verbal and non-verbal behaviours, the former being easier to perceive than the latter. The practice of radiographers introducing themselves to patients inspired by the #hellomynameis campaign[22] is proving popular, although only rarely is the radiographer's name remembered

- it is the friendliness of the greeting which is noticed, remembered and appreciated. Explanations about the procedure, what to expect and what happens after are even more highly valued and help alleviate anxiety. Many patients appreciated being shown their images and others would have liked to have been shown but did not feel comfortable asking. Fears and worries as well as curiosity can be allayed but only when vocalised and the Code of Conduct provides guidance for when patients ask questions:

Full and truthful answers must be given to any question reasonably asked by the patient. (Guidance notes, Code of Professional Conduct Section 1.3, p6).

However, this does not address the unasked questions in the minds of patients anxious about their diagnosis or simply seeking peace of mind regardless of whether their condition is treatable. Further exploration of communication skills teaching and training might address this hard-to-grasp aspect of diversity.

Discussion

The title of this paper is taken from a quote made by an interview participant and encapsulates the main argument; that the concept of diversity is not confined to social and cultural differences but should include psychological, emotional and attitudinal ones which may be concealed from view. This paper reports findings which indicate that psychological diversity exists within patients undergoing projection imaging and this affects their experiences, sometimes profoundly. Whether consciously or unconsciously hidden or disguised, patients' emotions, feelings, beliefs about and attitudes to their healthcare experiences are all information often unavailable to the radiographer. Communication is not simply the passing of information in one direction but a complex interchange between patient and practitioner; a successful and positive exchange involves on the part of the radiographer, highly developed skills in perception, attention and memory as well as emotional components of caring and compassion.[23] Not included in the themes presented in this paper were lack of time and pressure of work, although these were a strong, consistent and sometimes emotive thread which ran through the transcripts and often repeated within individual ones, indicating that patients do appreciate some of the challenges faced by compassionate and caring radiographers.

Critical appraisal of the research methodology suggests that the number of patients interviewed was deemed sufficient to reach saturation; the number of participants interviewed exceeded Hennink's criteria for both code and meaning saturation.[20] The research was conducted in the south-west of England which produced a predominantly but not exclusively white, middle class cohort of participants, although it is argued that emotions and feelings transcend cultural and ethnic boundaries as long as the environment is conducive to their expression; the supportive and non-judgmental approach taken in this research was intended to permit this. Imaging examinations varied with upper and lower limb, chest, abdomen and pelvic projections represented in the sample. The age range of the participants was considered broad enough to cut across generational differences although it could be argued that they are spread too thinly across the sample; a larger future study might address this potential shortcoming. The trustworthiness of the research has been evaluated using Charmaz's criteria of credibility, originality, resonance and usefulness[24] and appraised using the Critical Appraisal Skills Programme (CASP) checklist.[25]

Conclusion and recommendations

Recognition and acknowledgement of diversity is an important part of radiographic practice and education and this research broadens the definition of diversity to include psychological as well as socio-cultural differences, which would be useful when conceptualising compassionate person-centred care. Diversity should not be delineated solely by grouping patients into categories such as 'young' or 'the disabled' but should incorporate emotional states, beliefs and individual characteristics. The adapted technique taught and learned in radiography education and training is commonly associated with radiographic technique and production of the image; one recommendation from this study is to broaden the meaning of the term to include adaption of techniques in inter-personal skills and communication including an emphasis on non-verbal cues both exhibited and perceived. A further recommendation is to address the issue of informing patients who may wish to know more, but for whatever reason do not ask outright. Many participants noted that where care was perceived as sub-optimal or poor that this was not due to failings or flaws in individual practitioners, rather that organisational or cultural factors were in play as well as the time and work pressures discussed previously and acknowledged in the

Francis Report and in countless research papers before and since.[26] The challenges specified in the themes identified in this research suggest an emphasis in communication skills teaching on non-verbal cues and perception and understanding of emotions in the delivery of compassionate patient care. Further research into the challenges specific to the time-pressured, task-focussed, highly technical and rapid turnover environment of projection imaging radiography and how this impacts upon compassionate patient care would be an effective way of embracing and fostering diversity and equity in radiography.

Conflict of interest

None

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