ality trait model of motivation prevalent in much of clinical literature, which does place this sort of responsibility on patients, can negatively affect engagement with rehabilitation.^{20 21}

Implications for further research

Further research into the determinants of motivation is required. Ethnographic research into how patients are treated by rehabilitation professionals on the basis of labels such as "motivated" and "unmotivated," and the effects this might have on motivation, seems warranted. Research into how patients themselves categorise motivation might also be useful. All such research might help in maintaining motivation among rehabilitation patients, a task often taken to be "the most important, yet the most difficult part of the work of the therapeutic professions."²²

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- 1 Gubrium JF, Buckholdt DR. *Describing care: images and practice in rehabilitation*. Cambridge, MA: Oelgeschlager, Gunn and Hain, 1982.
- 2 Kaufman S, Becker G. Stroke: health care on the periphery. *Soc Sci Med* 1986;22:983-9.

- 3 Griffiths L, Hughes D. Typification in a neuro-rehabilitation centre: Scheff revisited? *Soc Rev* 1993;41:415-45.
- 4 King P, Barrowclough C. Rating the motivation of elderly patients on a rehabilitation ward. *Clin Rehabil* 1989;3:289-91.
- 5 Maclean N, Pound P. A critical review of the concept of patient motivation in the literature on physical rehabilitation. *Soc Sci Med* 2000;50:495-506.
- 6 Wolff BB. How do rheumatic diseases relate to economic potential as influenced by: personal attitudes and motivation. *Pa Med* 1969;72:68-70.
- 7 Clark MS, Smith DS. Abnormal illness behaviour in rehabilitation from stroke. *Clin Rehabil* 1997;11:162-70.
- 8 Kaufman S. Illness, biography, and the interpretation of self following a stroke. *J Ageing Stud* 1988;3:221-7.
- 9 Kaufman SR. Towards a phenomenology of boundaries in medicine: chronic illness experience in the case of stroke. *Med Anthropol Q* 1988;2:338-54.
- 10 Gold SJ. Getting well: impression management as stroke rehabilitation. *Qual Sociol* 1983;6:238-54.
- 11 Gilbert Nigel. *Researching social life*. London: Sage, 1993.
- 12 Patton M. *How to use qualitative methods in evaluation*. Newbury Park: Sage, 1987.
- 13 Strauss A, Corbin J. *Basics of qualitative research*. Newbury Park: Sage, 1990.
- 14 Weber R. *Basic content analysis*. London: Sage, 1990.
- 15 Fitzpatrick R, Boulton M. Qualitative methods for assessing health care. *Qual Health Care* 1994;3:107-13.
- 16 Anderson R. *The aftermath of stroke*. Cambridge: Cambridge University Press, 1992.
- 17 Tupper A, Henley S. Predictive factors in stroke outcome and implications for intervention. *Int J Rehabil Res* 1987;10:119-22.
- 18 Ibbotson J. Motivation—the occupational therapist's view. *Physiotherapy* 1978;61:189-91.
- 19 Wade DT. Who looks after stroke patients? *Br J Hosp Med* 1987;37:200-4.
- 20 Hoffman JE. Care of the unwanted: stroke patients in a Canadian hospital. In: Coburn D, D'Arcy C, New P, Torrance G, eds. *Health and Canadian Society*. Markham, ON: Fitzhenry and Whiteside, 1981.
- 21 Becker G, Kaufman SR. Managing an uncertain illness trajectory in old age: patient's and physician's views of stroke. *Med Anthropol Q* 1995;9:165-87.
- 22 O'Gorman G. Anti-motivation. *Physiotherapy* 1975;61:176-9.

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A valuable lesson

The doctor is on your side

It had been quite an ordeal already. A winter sports' accident had left me paralysed from the chest down, with numerous other injuries. I had been at a spinal injuries unit for rehabilitation for almost a year, and was being allowed home for weekend leave. A big concern had been a tight tracheal stricture, which had occurred as the result of the insertion of a tracheostomy tube a few days after the accident.

Fortunately, medical friends had found a surgeon who had been able to perform a corrective procedure, which was complex and specialised. This was done about nine months after the accident. The original tracheal reconstructive procedure had been a success, in that the narrowing had been improved, but a tracheostomy remained. I was relieved to have my speech again after so much frustrating silence.

The plan was to keep a tracheostomy in place below the surgical site until the scarring looked mature and the tracheal aperture was acceptable. This involved endoscopic evaluation under general anaesthetic and lasering to areas that looked suspect. Three months was the routine interval between procedures. Having a tracheostomy in itself was a trying experience. Secretions have to be suctioned frequently from the tube. Even though I could now do the suctioning myself, it was still quite burdensome.

The time had come for the first assessment since the major operation. Having recovered from the anaesthetic, the surgeon told me that the scar looked much improved. Lasering had been performed, but the tracheostomy tube needed to stay in until at least the next assessment. I was ambivalent. The outcome of surgery was heading in the right direction. On the other hand, I had a few more months in which to

endure a tracheostomy. I was hungry and probably greedy for progress. The surgeon must have sensed this, but it was difficult to discuss this so soon after the operation.

I was at home for the weekend feeling a little downhearted when the telephone rang. It was the surgeon. He explained again why the tracheostomy needed to remain. He empathised with me and said that he disliked tracheostomies and wanted to remove them whenever possible. This reminded me that he was on my side, not that I ever really questioned this. He had made it possible for me to regain my speech. But when you are grasping for every glimmer of progress, especially if not immediately deliverable, it is easy to lose sight of the fact that the doctor is working with you. Empathy and showing a motivation to help as a doctor is vital and may be strengthening for the patient, especially in difficult circumstances. This episode has reminded me of that now that my role is reversed.

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We welcome articles of up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.