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A Qualitative Study on the Experiences of Specialists on Patient-Oriented Decision Making in a Developing Country

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ABSTRACT

Introduction: Patient centered decision making is one of the main aspects of evidence –based medicine, in addition to being morally important. The aim of this study was to extract the experiences of clinicians on patient-centered decision making. ***Method*:** A qualitative study based on descriptive phenomenology method was done. Purposive sampling was used to select the clinicians from among faculty members of medical school. Focus Group Discussion (FGD) was used to gather the data .The discussion continued till the saturation of data was achieved. Content analysis was used for data analysis. ***Results***: The participants of FGD were 6 clinicians from various specialties. 218 codes were extracted from the data and they were categorized in 4 themes and 16 subthemes. The main themes were: good relationship with patients, respect to the opinions and beliefs of the patients, taking into account the needs, preferences and experiences of the patients, comfort and safety of outpatient and inpatient setting for patient, shared decision making. ***Conclusion*:** Patient centeredness based on the experiences of clinicians in an educational hospital is similar to other studies but in developing countries like Iran clinicians have contextual and cultural barriers to apply it.

Introduction

Patient's values and preferences is one of the cornerstones of Evidence Based Medicine.[1] Patient centered decision making has three components: 1) considering needs, wants and experiences of patients, 2) enhancing partnership and understanding in the patient-physician relationship and 3) offering patients opportunities to participate in caring process.[2] Furthermore, studies shows that patients express more confidence in doctors who have patient-centered behavior.[3]

Traditionally, physicians have utilized a paternalistic approach and decide on behalf of their patients, but this approach has been criticized in recent years.[4] Patient centeredness is a culturally sensitive issue, so that religious and cultural considerations ,especially in Islamic countries, should take into account in decision making process.[5]

Some studies showed that patient-centered care and decision making had a positive effect in health outcomes.[6,7] On the other hand, some of them did not report a positive effect. These controversies were because of different patient groups, varying preferences and different conditions.[8]

Applying the patient-centered decision making approach is highly related to physicians. Understanding physicians experiences and opinion is a critical issue particularly in developing countries with more traditional and paternalistic approach to doctor-patient relationship and clinical decision making. As most of the knowledge on this subject in developing countries is based on quantitative data and almost all of them are about physician-patient relationship and there is limited evidence, according to our search no evidence, on the experiences of physicians and their opinions about challenges in patient centered decision making so that a qualitative study was designed to discover the experiences of specialists on patient values, patient centered decision making in Iran as a developing country.

Materials and methods

In order to generate in-depth accounts of the physicians' "lived experiences" and their interpretations, a phenomenological approach was selected. The aim of this approach was to describe lived experiences or to find how the phenomenon (patient –centered decision making) is experienced by people.[9]

This study was designed to explore and describe the lived

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experiences of specialists in Tabriz faculty of medicine in North-West of Iran on patient-centered decision making, patient values and preferences and their decision making and relationship with patient process.

In this research we used the descriptive phenomenology method. According to this method, researchers are encouraged to "bracket" their own assumptions about the phenomenon in question. This helps researchers to take part in the descriptions of the participants without forcing the meaning into pre-defined categories.[10]

Exploring the lived experiences requires access to people who have experienced the phenomenon under study. Therefore, purposive sampling technique was used to select the participants from among internal medicine, surgery, pediatrics, psychiatry and emergency medicine specialists and subspecialists of medical school with more than 3 years of job experience as a faculty member in educational hospital and referral clinics. The participants were those who had enough information about patient-centered decision making and wanted to express their experiences. They were 11 specialists from different disciplines, so that diversity was seen in their specialty, age and sex and job experience. Data collection was accomplished through Focus Group Discussion (FGD). Participants took part in FGD session at the due date and the mentioned time in their invitation letter. Due to their educational and patient visit programs in the hospital and clinic in the morning and afternoon, we invited them at noon along with serving lunch.

The session was held in Education Development Center (EDC) meeting room which was familiar to them and close to the educational hospital.

Just before beginning the FGD, an informed consent was given to physicians. They agreed to take part in the study and to record their voice. As one of the participants was not allowed to shoot video of the group discussion, camera was not used to record the discussions.

Each participant was given a code for naming verbally or writing their experiences. These codes were also used in the analysis process.

Before conducting the semi-structured FGD, a text consisting of the main objectives of the study was prepared in order to guide the discussion by the moderator. This sheet consisted of three parts: opening question, body and closing.

An experienced moderator (J.S.T.) was leading the meeting and a note taker and observer were recording the discussions. All of the researchers (moderator, note-taker, and observers) were physicians and had common language with the participants. The FGD session lasted 2 hour and 30 minutes.

The session started with the opening question with supervising role of the moderator. When one of the participants expressed his/her experiences, it made others remind their own and the debates continued in this way. Most of the experiences and ideas were expressed in a short time and the saturation of data was achieved after 2 hours of discussion. As a validating step, the moderator returned to each participant offering him/her the opportunity to identify any discrepancies in information (Member check). Some of them revised the brief summary (respondent Validity). Immediately after the FGD session, the records were sorted and the researchers began to listen to tapes and transcript them. After listening to tapes, verbatim content was written by two independent researchers. It was followed by comparing and matching the transcripts and note-taker's records, and then all were integrated and the final revision was done by a third researcher.

All of the transcripts and notes were read to make sense of them. The integrated transcripts and notes have been read several times and the recordings were reviewed to find out participants' tone of voice.

Finally 218 codes were extracted. Each code highlighted that there was a word or phrase in the transcript that had significant meaning. Statements that were related to the phenomenon of patient centeredness were collected and categorized. Therefore, four major categories and 20 subcategories were made. Content analysis method was used to analyze the data. In order to rigor the data, we used respondent validity, member check, purposive sampling and researcher triangulation already mentioned.

The research proposal was approved in research committee of Medical Education research center and ethics committee of Tabriz University of Medical Sciences.

Results

The findings were presented as themes and subthemes identified from physicians' experiences on the concepts of patient centered decision making.

The fundamental aspects of patient centered decision making were 5 themes:

1. Good relationship with patients
2. Respect to the opinions and beliefs of the patients
3. Taking into account the needs, preferences and experiences of the patients.
4. Comfort and safety of outpatient and inpatient setting for patient
5. Shared decision making

1.Good relationship with patients

This theme included of 5 subthemes:

Rapport building, dignity, verbal and non-verbal communication, a balanced relationship and good relationship with patient's family.

Some quotes in this theme were as follows:

"While visiting or talking to a patient you have to show that a doctor is like a friend to him/her not a person to prescribe medicine. This creates compliance and trust."

"Verbal and non-verbal communication, eye contact, acknowledging the patient are very important. Patient should be treated like a human being not a medical case."

"Based on my experiences, some of doctors do not have proper eye contact and some even do not listen to their patients."

"Asking about social and familial aspects of health and disease, talking about patient's family, friends and career improve the trust."

"In our place, in outpatient clinics, there are so many

patients, it is crowded. We don't have time to listen to the patient, we just take a little time to look at their lab results. "

2. Respect to the opinions and beliefs of the patients

This them composed of 7 subthemes : caring for the patient, valorizing the patient, considering patient's needs , taking into account patient's values , respect to patient's religious beliefs , considering patient's rights, avoiding paternalistic approach. Some quotes in this theme are as follows:

"In our culture, some physicians think that they are doctors, they studied in medical school, so they are superior and the one who should decide. Patient is someone who needs the doctor."

"I never use my cell phone in visiting room. Sometimes patients appreciate it and mention that other doctors that they referred to were not like this."

"We always think that we are right and we cannot accept that patients have rights."

"Respect to patient's religious beliefs makes him or her to trust you. Some beliefs such as fasting, positions in praying, for instance."

"When my patients ask about traditional remedies, I always recommend them, if they are not harmful, this leads to more compliance and trust."

3. Taking into account the needs, preferences and experiences of the patients.

Empathy, giving the right information to the patient, follow up, finding and solving the main problem, allocating enough time for each patient were the subthemes of this main theme.
The following quotes are examples of what the clinicians expressed as their experiences:

"Sometimes I think that if I was on the other side of this desk what would I expect?"

"Patients are afraid of surgery. Some of patients whose doctors decided to do surgery come to me in order to change the decision. I spend some time to explain them the options and most of the time they agree to have a surgery."

4. Comfort and safety of outpatient and inpatient setting for patient

Setting of the office, waiting room, hospital wards and patients comfort and safety were the other theme with following subthemes:
Respect to the time of the patient, considering the socioeconomic state of the patient, helping patients to use the facilities in outpatient and inpatient settings, appropriate design of the office, waiting room and hospital wards. The quotes are:
"Some of my patients cannot stay in city more than one day. These are given priority in my office to cover what is needed in a day."

"We need to design a web-based or electronic system to make appointments in order to reduce the wasting time."
"In pediatrics hospitals, mothers who stay with their children do not sleep well because there is no suitable bed for them in those small rooms. We need sofa beds in our rooms."

5. Shared decision making

The clinicians' experiences on shared decision making were categorize in 3 subtheme:
The patient's right to choose, considering patient's preferences as a part of decision making process, giving adequate information to patients based on their educational level. One of the clinicians believed that as far as his experiences showed, there was no room for shared decision making in our culture.
The following are some quotes:

"When I explain to my patient all the options such as surgery or medicine, and ask him/her or their family to decide, this leads to better relationship and compliance, they seldom go to another doctor."

"In our culture we, cannot explain patient the options and ask him/her to decide, because we live in a country that still a doctor is someone who is superior and knows more. When I tell my patients that these are the options and ask him/her to decide, most of them say that you are the doctor not me!"

Discussion

The aim of this study was to get the experiences of clinicians on the concept of patient centeredness. The results showed that clinicians' experiences covered most of the aspects of this concept but they had some barriers to apply it.
The concept of patient centeredness has 5 themes. One of them is doctor-patient relationship. In a qualitative study by Mendoza et al. on health care quality, 12 clinicians expressed that relationship with patients is a crucial point in health care quality.[11] The results of Mendoza's study were in line with ours. Pawlikowska et al. studied the verbal and non-verbal behavior of doctors and patients in primary care and their relationship with patient enablement.[12] They concluded that behavior like empathy, smiling , nodding were the most important non verbal skills . In our study, clinicians' experiences showed the same importance of these skills in doctor-patient relationship. Gorawara-Bhat et al. in a qualitative study showed the significance of eye contact in patient centered communication.[13] In our study the clinicians emphasized this issue in subthemes of patient-centered decision making. On the other hand, their experiences showed that one of the causes of inappropriate relationship with patients was the large number of patients. Respect to patients' beliefs was another main theme of our study. Mendoza mentioned in his study that respect and response to patient's preferences and values were the basic aspects of patient-centeredness. They stressed that patient centered decision making is to focus on what is important to the patient.[11] The clinician in our study had the same experiences. In Iran Yamani et al. in a qualitative study on the ways of teaching professionalism to medical students,

extracted the themes such as respect and patient rights in decision making.[14]

Considering patient's expectations was the other main theme in our study which was in accordance with Yamani and Mendoz's findings. Bormely et al. concluded that considering the patient's needs and wishes was an important aspect of designing the hospitals.[15] One of the subthemes in our study supported this result. Clinicians' experiences in our study on the comfort and safety of the patients as a theme, showed that changing the design of waiting room, doctor's office and also developing an electronic system for appointments were very important in patient-centeredness.

Shared decision making was mentioned in most of the studies.[1,2,4,7] In our study clinicians stated that shared decision making could help gaining patient compliance. One of them did not agree because of the context and culture of Iranian patients and their beliefs in the paternalistic approach of doctors in Iran.

The similarity of themes and subthemes among cultures shows that the principles of patient-centeredness are the same in different cultures but there are contextual and cultural barriers to apply them. This conclusion helps developing the educational resources for patient value and patient centered-decision making in different cultures.

Conclusion

Patient centeredness based on the experiences of clinicians in an educational hospital is similar to other studies but in developing countries like Iran clinicians have contextual and cultural barriers to apply it.

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Ethical issues

Participants' information was kept confidential.

Conflict of interests

No competing interests to be declared.

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