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ABSTRACT

OBJECTIVE: To feel involved in decisions about atrial fibrillation (AF) treatment, patients need supportive communication from cardiologists. Shedding light on cardiologists' perceptions of patient involvement in AF care settings is of importance. We examine (i) how cardiologists describe patient involvement and communication related to shared decision-making regarding AF treatment, and (ii) their perceptions of efforts to involve patients in the treatment decisions.

METHODS: Ten cardiologists were interviewed in four Swedish hospitals. A qualitative content analysis was performed on the interview data.

RESULTS: Cardiologists' perceptions of patient involvement in treatment decisions are framed in terms of (i) ideology, (ii) experience, and (iii) responsibility.

CONCLUSION: By taking into account the patients' feelings in the consultations, and by actively encouraging the patients to be involved, the cardiologists contributed to patient involvement.

PRACTICE IMPLICATIONS: One key to improving compliance with legislation aimed at increasing patient involvement in treatment decisions could lie in paying attention to physician-patient communication and the conditions for patient involvement in decision-making about treatment.

KEYWORDS: Atrial fibrillation, Communication, Consultation, Shared decision-making, Patient involvement, Patient participation, Physician-patient relation

Cardiologists' experiences and perceptions of patient involvement and communication related to shared decision-making regarding atrial fibrillation treatment

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1. Introduction

We focus on cardiologists' efforts to involve patients with atrial fibrillation (AF) in treatment decisions. Guidelines in the field of cardiology highlight patient involvement in decision-making about AF treatment (National guidelines for cardiac care, 2008). The patients' dignity, integrity, involvement, and security must be ensured in a more explicit manner than in the past (The National Board of Health and Welfare, 2012).

Selecting treatment options

The selection of anticoagulation therapy for stroke prevention is often based on scores to aid decision-making for thromboprophylaxis in nonvascular AF (Lip et al 2015). Cardiologists also base AF treatment choices on national and international guidelines, and these are useful for presenting patients with information about the effectiveness of treatments (National guidelines for cardiac care, 2008; January et al. 2014). Treatment options for AF are increasing and constantly evolving (Dobesh and Fanikos, 2015; Camm, 2012). Several aids have been developed for cardiologists using decision analysis to guide patients in the choice of antithrombotic therapy of AF (Hargraves and Montori, 2014; Eckman et al 2008). Patient involvement relies more and more on the use of these decision aids to assist the patient in

choosing the best treatment option. However, the recommendations are based at the group level, and knowledge from the individual level is lacking (Lip et al 2015). Accordingly an individual assessment of each case is needed, which is based on patients' preferences (Agoritsas et al 2015). Many AF treatment decisions are preceded by the cardiologist weighing a reasonable improvement in well-being against risks to the patient (Camm, 2012). Treatment choices are often limited to pharmacological therapy for either rate or rhythm control, owing to the high risk of side effects and drug toxicities (Camm, 2012). Age-related physiological changes, the effects of antiarrhythmic agents, and the effectiveness of catheter-based ablation are not well represented in clinical studies (Kazemian et al 2012; Hakim et al 2014). When considering anticoagulation therapy for stroke, patients' preferences need to be talked over (Hargraves and Montori, 2014).

Patient involvement in decision-making

Patient involvement and communication in decision-making is a high priority, and patients' self-determination and autonomy pose major and growing challenges (Muhli, 2010). In biomedical research, patient involvement is conceptualized as an effective tool for health self-management (Barello et al 2012). Published studies on decision-making about treatments describe ways in which medical communication can include individual patient preferences within the broader context of the therapeutic relationship, to help patients make autonomous decisions and enhance patient involvement (Entwistle et al 2006). In this study, we discuss AF consultations regarding patient involvement and influence on the decision-making process, which is viewed as an interactional process between patients and cardiologists.

Patient involvement in treatment is highlighted in the recent revision of the Patient Act in Sweden (SFS, 2014:821). Patient involvement is conceived as a strategy enacted top-down by the healthcare system to mobilize patients to engage in managing their own diseases.

However, variations in the preferred level of involvement by patients were found; for example, an increase in age can lead to a decrease in the desire to participate, while higher levels of education tend to increase involvement (Coulter, 2011). One review found that patients' preference to participate in medical decision-making increased over time (50% in studies prior to 2000, compared with 71% of studies after 2000) (Chewning et al 2012).

Shared decision-making

This study proposes a theoretical and conceptual basis for patient involvement based on the shared decision model by Elwyn et al., (2014) and its relation to decision-making regarding treatment by patients and cardiologists in consultations. In the field of research on shared decision-making, patient involvement is essential for incorporating the patients' beliefs, values, and preferences (Elwyn and Miron-Shatz, 2010). In shared decision making, the patient and cardiologist share their areas of expertise, consisting of scientific knowledge and personal preferences and experience, respectively. Negotiating and committing to a collaborative agreement regarding health care decisions also occur in this model (Elwyn et al 2014). Cardiologists' provision of evidence-based information about options, outcomes, and uncertainties, together with decision support counseling and a system for recording and implementing patients' informed preferences, are all components of the decision-making process (Elwyn and Miron-Shatz, 2010). Shared decision-making also involves establishing patients' perceptions about the treatment options, and ensuring that patients have an adequate understanding of the information provided (Edwards and Elwyn, 2009). This model is a tool for raising awareness about communication in health care encounters and patient involvement (Elwyn and Charles, 2009).

Physicians' ideas of patient involvement have been studied before (McGuire et al 2005). Research on decision making during medical consultations mainly focuses on involving the patient on both theoretical and applied levels (Laidsaar-Powell et al 2013). A study conducted among cardiology health professionals in Swedish hospitals found that physicians and nurses viewed time constraints as a barrier for patient involvement (Arnetz et al 2008). In our earlier research, based on video recordings of the interaction between patients with AF and nurses or physicians during consultations, we focused on patient involvement in shared decision-making (Siouta, 2016). However, to our knowledge, there are few studies describing cardiologists' perceptions of patient involvement in AF care. This study aims to examine how cardiologists describe patient involvement and communication related to shared decision making regarding AF treatment, their perceptions of efforts to involve patients in the treatment decisions, and how the cardiologists handle treatment decisions.

2. Methods

Design, setting and participants

We conducted interviews with cardiologists, and used an inductive content analysis to evaluate their input. Data were collected at four hospitals in Sweden, from January to December 2014. Ten cardiologists were interviewed. Cardiologists were strategically selected by the first author (ES) responsible for the data collection. The participants were selected with the intention of achieving a variance (Polit and Beck, 2013) based on sex, age, and length of clinical experience in cardiology practice. Table 1 illustrates the characteristics of the participants.

Insert table 1

Procedure

An invitation letter was sent to potential participants, informing them of the study purpose. Interviews were conducted by the first author (ES) at the participants' offices at their workplaces. The interviews were based on topics relevant to patient involvement in the shared decision-making model (OPTION) developed by Elwyn and colleagues (Elwyn et al 2005) and translated into Swedish (Siouta, 2016). The OPTION instrument focuses on health professionals' communication and including patients in the decision-making processes. The instrument is used in research today to assess consultations between patients and health professionals in several health care areas (Couët et al 2013). The OPTION instrument consists of 12 items (Elwyn et al 2005). Informants were asked to reflect on each item, including factors influencing patient involvement in the decision about AF treatment. Interviews lasted from 20 to 40 minutes. The interviews were audio-recorded, and considered important aspects of patient involvement in decision-making in AF treatment with questions such as: 'How did the cardiologists involve patients in the treatment decisions in the consultations?' and 'What preconditions facilitate patient involvement in treatment decisions?' and 'Which kinds of efforts did the cardiologists make to involve patients in the treatment decisions during the consultations?'. Ethical approval was obtained from the Regional Ethics Committee in Linköping, Sweden (Dnr. 2014/146-32).

Data analysis

Transcripts of 10 interviews were analyzed according to qualitative content analysis (Krippendorff, 2014). Research using qualitative content analysis focuses on a systematic procedure to extract the main content (Krippendorff, 2014). Our analysis focused on the respondents' perceptions of patient involvement, as well their perceptions of their own efforts to involve the patients in AF treatment decisions during consultations, and how the

cardiologists handled treatment decisions. Categorization constitutes a key element in this analysis. First, the transcribed interviews were read and checked. Subsequently, the transcripts were read multiple times, searching for statements describing experiences related to the aim. Sentences that shared the same meaning were condensed and coded. The codes were then transferred to a coding page, where similar codes were grouped together. By comparing content differences and similarities between the codes, subcategories and main categories were created.

Cardiologists' perceptions of patient involvement in shared decision-making can be described as frames or interpretation schemes, which people use when they interpret and understand situations (Sarangi, 2010; Hellström Muhli, 2003; Goffman, 1981). ES coded the data; preliminary categories and alternative codings were discussed with KK, UHM, and BF until consensus was reached to in describing more abstract dimensions of involvement and communication.

3. Results

The findings present cardiologists' descriptions of patient involvement and communication related to shared decision-making regarding AF treatment and their perceptions of efforts to involve patients in treatment decisions during consultations. The findings are summarised in Table 2. Appropriate excerpts describing cardiologists' perceptions are presented in the text to illustrate the categories.

Insert table 2

3.1 Perceptions of patient involvement in shared decision-making

3.1.1 The mode of talking and understanding of involvement.

Cardiologists' descriptions of patient involvement and communication related to shared decision-making regarding AF treatment can be classified into one main category: (i) the mode of talking and understanding of involvement. This category encompasses three subcategories: (1) Ideological frame, (2), Experience frame and (3) Responsibility frame.

1. Ideological frame

Our analysis shows that cardiologists see patient involvement as an ideological issue based on a humanistic approach supporting patients' efforts in becoming involved in decisions regarding their care and treatment. However, this idea is not supported by all cardiologists. Instead, this view polarizes the medical profession, as illustrated in the quote below. The cardiologist states, "we are all people", which strengthens the ideological view of patients' involvement. Thereby, the cardiologist includes him/herself in this group. The cardiologists are divided into those who reinforce aspects of the biomedical model of care, and those who also emphasize negotiating perspectives and the importance of understanding patient needs.

*Cardiologist 1: I am part of the ideological group
that reflects a lot on value and patient focus, and
we are a small group that has a small idea of
achieving patient participation. I think that we
have industrialized away the patient from
humanism and it is very important not to lose the
human being in this context. We are all people.
Personally I think that the patient should be
better informed. Laws and regulations guide us.
But apart from laws, this is an ideological issue.*

2. Experience frame

The cardiologists in our study oriented their descriptions of patient involvement toward professional experience and the use of dialogic communication skills that come with experience. They expressed the belief that the use of communication skills to involve patients depends on the professional experience of the practitioners, and that these improve with clinical experience. According to the cardiologists we interviewed, communication guidelines for involving patients in decisions are not seen as necessary for experienced cardiologists, but less-experienced cardiologists may need them. They reported that building confidence by displaying patients their expertise was something that came with experience.

Cardiologist 2: *I understand more now than when I was younger, that we must meet and listen. However, it is not so easy, but I think that some wisdom has come with age.*

3. Responsibility frame

Our analysis shows that cardiologists see patient involvement as actively making decisions. Cardiologists describe the idea of patient involvement in treatment decisions positively, but sharing the responsibility for actually making the decision with patients is difficult in practice. Our interviewees expressed the notion that it is good for patients to be involved in decisions, but that it is the cardiologists who should take the decision. They desired patient involvement, but at the same time seemed unwilling to hand over decision-making to the patient, arguing that patients may not understand, may act irrationally, or may not act to promote their health. They described strong attitudes that come into play, where ultimately the responsibility is still seen as resting on the cardiologists. Patients expect them to take decisions, which is reasonable because cardiologists are more knowledgeable about AF treatment. Our interviewees also expressed the belief that the process of making and documenting treatment decisions would change in the future. They surmise that a shift of power towards the patients will occur, and that they would eventually meet better prepared and informed patients; the incorporation of patients' preferences into treatment decisions would increase. They indicated that patients would explicitly demand increased involvement in decision-making in the future, in line with the new law requiring patient involvement.

Cardiologist 3: *I think the medical service will talk a lot more about this, or we already do, but it will change how we make the decisions. We will perhaps also document the decision-making in another way in the future. It is still difficult, I think. I mean, my hope and feeling is that the patient agrees with the decision, but this is my way of thinking. In many cases, I hope that it is so but there are probably times when the patient feels disregarded. There is a lot of talk about having to involve the patient. That the power will shift a little towards the patient.*

3.2 Perceptions of efforts to involve patients in AF treatment decisions

Cardiologists' perceptions of efforts to involve patients in AF treatment decisions can be classified into three main categories: (i) Assessing patient-related avenues for involvement, and (ii) Taking patients' feelings into account and (iii) delaying the decision as a strategy for involvement.

3.2.1 Assessing patient-related avenues for involvement

This category encompasses three subcategories: (1) Assessment of patients' cognitive resources, (2) assessment of patients' knowledge about AF and its treatment, and (3) assessment of patients' interest and desire to be involved.

1. *Assessment of patients' cognitive resources:* One way cardiologists contribute to patient involvement is by assessing the patients' abilities to be receptive to information. Cognitive impairments and an assessment of the patients' susceptibility to information are taken into account when considering patient involvement in the treatment decisions. This is done by asking questions to get feedback from the patients.

Cardiologist 7: Yes, you understand it from their look. The feedback you get when you inform the patients. From some of them, you know at once if they have understood because they have questions. Certain elderly patients, I believe, are perhaps more often both afraid and do not ask that much. Then you must repeat things. I usually repeat it, from the beginning, just to see if I get any response. With older persons it is testing whether you get a response or not. You notice if they have understood or not. Otherwise you must repeat it all again.

2. *Assessment of patients' knowledge about AF and its treatment:* This is another way to contribute to patient involvement. The perception is that patients are often misinformed, and need to relearn the facts and options.

Cardiologist 1: *If I present a treatment strategy that we shall do an X-ray of the coronary artery in about 3-4 weeks and we put in certain medications, first I give oral information about discharge and explain everything, and then I give a written answer, and then when the patient has read this information I say, "What are we going to do now, what are the future plans?" This is what I try to do with all my patients; I ask the question, "What are the results of the tests and the X-ray?" Even if I have all the answers, I sort of want the patient to take part, so that they know why they are here and what is planned, so I check that they are really on the right track.*

3. *Assessing patients' interest and desire to be involved:* Preconditions for patient involvement described by the cardiologists are patients' interest and desire to be involved in treatment decisions. Factors such as patients' personality, whether they live alone and whether they have children affect their desire to be involved. Other factors include the patients' physical impairments and comorbidities, age, cultural differences, and degree of risk averseness. Assessing the patients' desire to make decisions can be difficult. Our cardiologists saw patient involvement as a question of attitude, not knowledge.

Cardiologist 10: *Then you get a typical question, "What do you think?" or they might say, "What do you think we should do?" Is it a question of not having enough knowledge to be able to make a decision, or is it more a question of attitude? There are many aging and more educated patients who enter the scene, so it is a question of attitude, not a question of knowledge.*

3.2.2 Taking patients' feelings into account

This category encompasses two subcategories: (1) To register the emotional expressions of the patient, and (2) to confirm and understand the patient.

1. *To register the emotional expressions of the patient:* The analysis shows how cardiologists orient patient involvement in decisions towards the ability to register the emotional expressions of the patient. Cardiologists observe the patients' signals of anxiety and fear of treatment. They observe patients' body language for signs of fear, but they also expressed that they felt inadequate to explicitly ask whether patients were; "It is easy to neglect the patients' anxiety and fear of treatment," one cardiologist put it. We found that when patients were afraid, they showed resistance to the AF treatment proposed. The patients with the greatest fears were those who were treated with warfarin:

Cardiologist 3: *The patients' anxiety or fear. Yes, you feel it at once. You see it at once. You must go slowly forward and you feel that peculiarly, this is no verbal communication, it is the whole atmosphere, the body language and everything, you feel it at once. One, whether they are afraid or not, and two, whether they want to take anticoagulants or not. Those who have the greatest fear in the world start taking warfarin. Then you can explain that there are other things, and certain patients are happy but others are terrified... So this is something that is not quantifiable. This is what is called art in medicine. You must talk, meet people, once, twice, three times. The longer you work, the more sensitive you are about this. If you don't get tired and aren't bothered by it at all, you become sensitive to this.*

2. *To confirm and understand the patient:* As shown, the cardiologists believe that they take patients' feelings into account in consultations by giving patients time to talk about their feelings and by seeing the person behind the patient. However, they also believe that it is important for the patients to be comforted and to be understood.

Cardiologist 3: *But they (patients) want to be much more understood. They seek relief and they want us to understand how hard it is for them, that you confirm that you understand that this is extremely hard for them and so on. That they can devote a rather long time to tell how difficult and hard it is. It is almost as if they want to be a little comforted in some way.*

3.2.3 *Delaying the decision as a strategy for involvement*

This category encompasses one subcategory: (1) the cardiologists made it possible for the patients to reflect before agreeing to treatment

- (1) *The cardiologists made it possible for the patients to reflect before agreeing to treatment:* : Although the time of the consultation is perceived as limited, the cardiologists offer a space for discussion, where the patients can say no to treatment, even if the cardiologist recommends it. It is dangerous to involve patients in decisions if they do not feel prepared and informed, the cardiologists argue, and it is important not to frighten the patients. Another view is that patients should be given time to reflect on the decisions. The cardiologists noted that they made it possible for the patients to reflect before agreeing to treatment by discussing solutions together; the patients then go home and think about suggestions for treatment. This view is described as follows:

Cardiologist 4: *If the patients hesitate and don't know what they want to do, after I have presented the*

possibilities and propounded what I think the patients should do, then I let the patients go home and ponder and then call me. Yes, it is rather common for those who are scheduled for an operation, such as fibrillation. I would say about every third patient. They can come back. They want to go home and think. Then they call me perhaps a week or two later, once they have considered the matter.

4. Discussion and conclusion

Discussion

As the results show, the mode of talking and understanding are categorized in frames of (i) ideology, (ii) experience, and (iii) responsibility. However, cardiologists' contributions and efforts to involve the patient in AF treatment decisions were also described as features of professional assessment of the patients' cognitive resources, the patients' knowledge about AF disease and treatment, and the patients' ability and desire to make treatment decisions. This means that cardiologists assess the patients' cognitive abilities before any attempt is made to involve the patients in decision-making. Cardiologists therefore have a dual function in the consultation, namely to assess the cognitive abilities and to assess whether support for patient involvement is possible. If the cardiologists assess involvement to be possible, strategies for patient involvement are formed in subsequent communications.

However, in our study, the overall attitude to patient involvement is a question that polarizes cardiologists. Those who reinforce aspects of the biomedical model of care are anxious about patient involvement in AF treatment decisions and those who support the possibility of negotiating perspectives and the definition of patient need, which contributed to patient involvement. The cardiologists we interviewed focused their descriptions of patient

involvement toward their own communications skills, which, they admitted, develop over time and with clinical experience. They believed that the response to and use of communication skills to involve the patient depend on the cardiologists' experience, which improved with experience. We therefore conclude that the boundaries of professional expertise still control whether patients are involved in treatment decisions. In other words, there is still tension in separating professional descriptions of meaning from policies of patient involvement in treatment decisions. This tension is manifest in the way cardiologists deal with data in these kinds of professional settings and contexts. The question to be asked here is how to implement a breakthrough in patient involvement, and whether it is at all possible and desirable. However, younger cardiologists may need those guidelines. The cardiologists we interviewed reported feeling positive about the concept of patient involvement, but sharing the responsibility for decision-making seemed difficult in practice. They said that it was good for patients to be involved in the decisions, but that it was the cardiologist who often made the decisions. Here the cardiologists present an example of good policy that is not implemented in practice. The patients have not always had the chance to select their AF treatment, and the cardiologists may be afraid of making mistakes, or not working according to guidelines. However, they reported that they attempted to build confidence by appearing knowledgeable to the patient. As has been noticed in other studies, patient involvement can come into conflict with other values concerning professional responsibility (Blakeman et al 2016).

Shared decision-making

Siouta et al. showed that shared decision-making requires supportive communication aimed at building confidence and developing a sense of clarity, a feeling of being understood, and a feeling of trust (Siouta et al 2015). It is important to problematize the patients' own understanding of their situation. Developing the patients' sense of trust in their cardiologists

through a consistent, consultative relationship is one part of this process. However, it can be quite difficult to present evidence to patients in ways that do not overburden them, and which encourage their involvement. Developing methods that promote an effective and efficient form of communication between all parties involved is therefore a highly prioritized topic in research on shared decision-making (Siouta, 2016).

If patient involvement in decision-making about treatment options is desirable, many tools are available to support decision-making situations that are common in medical practice (Montori et al 2013). However, the question is whether these tools are well-suited for actively facilitating communication between cardiologists and patients. Consultations can be and are still intimidating situations for AF patients, who state that they would need to acquire knowledge and build up their confidence and ability before they could become effectively involved in the decision-making process regarding treatment (Siouta et al 2015). It is thus better to support the conversation when it takes place during the visit. Patients may express a desire to receive more information about their AF treatment and disease, but they do not demand an active role in the decision-making process (Siouta et al 2015). Shared decision-making requires the ability to see patients as active participants in the care process, not simply as recipients of care but more as co-actors who participate in the process. With this approach, involvement is therefore a construction between patient and cardiologist. Healthcare personnel may understand and follow the guidelines very effectively, but a particular treatment may not always be the right course of action for a particular patient. When a person-centered approach is in conflict with an ambition to follow external guidelines, shared decision-making is based on the assumption that it is acceptable, important and probably encouraging to involve patients in the decision-making process and strengthen patients' autonomy (Montori et al 2013; Alonso-Coello et al 2008). Patients should take part in decisions where multiple treatments are

available, and where such alternatives are relatively free of detriment or harm (Montori et al 2013). These may be important issues when it comes to enhancing patients' satisfaction, compliance and understanding (Joseph-Williams et al 2014) considering that patients must live with the consequences of their treatment decisions, including side-effects, risks, benefits, and other effects on their day-to-day lives. Knowledge and the encouragement to think about personal values alone are unlikely to support actual involvement in shared decision-making, for a large number of patients, if they do not wish to participate in making the decision (Joseph-Williams et al 2014; Burton et al 2010). However, if patients are involved in decisions regarding their treatment, they are more likely to carry out and adhere to the treatment plan, which in turn leads to better results (Montori et al 2013).

Methodological considerations

Data were collected from interviews with 10 cardiologists. An adequate number of cardiologists were selected to achieve a high value of the findings in terms of qualitative analysis. A descriptive qualitative design was used, not a statistically representative sample, no quantification of the informants answers was given. The use of interviews with a clinical sample (Table 1) and qualitative content analysis reveal new relevant aspects of patient involvement and decision-making in the consultations. Ten cardiologists from one country/culture were interviewed and their biases and world views are likely to be similar. To strengthen the study, Polit and Beck, (2013), the cardiologists in the sample were strategically selected to represent both genders and different levels of experience of practicing cardiology ranging from 2 to 20 years. Therefore, we believe that the value of the findings is high. The transferability of the results might be seen as an emphasis on the concept, involvement, and not as being representative of all professional groups. One important aim for future research is to explore

how nurses experienced patient involvement in consultations with AF patients, as well as how they promoted involvement and communicated with these patients.

Conclusions

We found that the way cardiologists contribute to patient involvement is by assessing the patients' abilities to be receptive to information. Cognitive impairments are also taken into account when considering patient involvement in the treatment decision. Cardiologists form a subjective impression of the patients' likelihood to be receptive to information before providing it. To pedagogically inform patients about various treatments can be difficult, especially when statistics on pros and cons must be explained in each individual case. Cardiologists do not routinely implement shared decision-making in their clinical practice in Sweden.

Practice implications

Cardiologists should problematize patient involvement and decision-making regarding AF treatment decisions in consultations when trying to meet patients' expectations to provide a quality experience. This problematizing requires more interest in the patients' perspective and opinions. However, this would require a completely different approach to consultations, including a more flexible schedule allowing extra time for patient-focused encounters.

Authors' contributions

XX was primarily responsible for collecting data, management analysis, and writing the manuscript. XXX, XX, and XX took part in the analysis and discussed content categories. All authors critically read, revised, and approved the final manuscript.

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Table 1. Characteristics of participant cardiologists (n = 10).

Variables	Physicians n=10
Gender, n	
Male/ Female	7/3
Age, range years	30—57
Types of hospitals, n	
University	6
County	4
Clinical experience in cardiology yrs exp	
Fewer than 2 years	1
2 to 10 years	6
11 to 20 years	3

Table 2. The findings presented as categories and sub-categories

Categories	Subcategories
The mode of talking and understanding of involvement	Ideological frame
	Experience frame
	Responsibility frame
Assessing patient-related avenues for involvement	Assessment of patients' cognitive resources
	Assessment of patients' knowledge about AF and its treatment
	Assessment of patients' interest and desire to be involved
Taking patients' feelings into account	To register the emotional expressions of the patient
	To confirm and understand the patient.
Delaying the decision as a strategy for involvement	The cardiologists made it possible for the patients to reflect before agreeing to treatment

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