

## Experiences of Cardiac Patients and Healthcare Providers Regarding Involvement in Health Care Decisions

Enaam Al-Ananbeh\*

Assistant Dean, Mutaa University Princess Muna College of Nursing, Amman, Jordan.

**\*Correspondence:**

Enaam Al-Ananbeh, Assistant Dean, Mutaa University Princess Muna College of Nursing, Amman, Jordan. Tel: +962-779290338.

**Received:** 20 August 2020; **Accepted:** 06 September 2020

**Citation:** Al-Ananbeh E. Experiences of Cardiac Patients and Healthcare Providers Regarding Involvement in Health Care Decisions. Nur Primary Care. 2020; 4(5): 1-11.

### ABSTRACT

**Background:** Health care providers (HCPs) play a key role in involving patients in health care decisions; they are the best patient's advocates in all health settings. Patients' involvement in health care decisions has been associated with improved treatment outcomes. Little is known about cardiac patients and HCPs experiences regarding involvement in health care decisions in Jordan. Therefore, it is needed to explore this phenomenon from both patients and HCPs perspectives.

**Aims:** To explore the experiences of cardiac patients and HCPs regarding their involvement in health care decisions.

**Design:** Descriptive phenomenological approach of Husserl (1962).

**Sampling Technique:** A purposive sample consisted of sixteen cardiac patients who were admitted to a public hospital in Jordan and twenty five HCPs were interviewed.

**Data Generation:** Semi-structured interviews were used over a period of six months (December 2018-May 2019).

**Data analysis:** A five – step technique proposed by Giorgi (1985) was used.

**Results:** Four major themes in relation to experiences of cardiac patients and HCPs: 1) The approach used by HCPs in communicating with patients is comforting, 2) Information provided to patients is helpful, 3) patients preferences regarding D.M style vary, 4) Sociocultural influence and religious factors influence patient's role in D.M.

**Conclusion:** Patients and HCPs generally, have positive attitudes toward active involvement in D.M. Most patients preferred to rely on HCPs, to take the final decision. Further, they addressed time limits and workload as major barriers to involve patients in health care decisions. The differences in D.M styles preferences with different values should be considered to support patient's involvement that is consistent to their values for best outcomes.

### Keywords

Decisions Making, Healthcare decision, Shared D.M, Experiences of Nurses and Experiences of Physicians.

### Introduction

Decision-Making (D.M) is a cognitive process by which a course of action is consciously chosen from a group of available alternatives to achieve a preferred outcome [1]. Decisions related

---

to health issues are considered unique and individualized [2,3]. The increasing emphasis on the individual's choice in health care treatment has contributed to the growing trend for Patient Involvement (PI) in decision-making [2,4].

Patient Involvement, as a concept, is associated with other terms such as patient engagement, collaboration, empowerment, partnership and participation [5,6]. Some authors defined it according to the shared decision-making model [7]. Others defined PI within the context of humanistic values [6] or linked the definition with patient - centered care putting patients at the center of health care [8]. Active involvement of patients in D.M as a component of patient-centered care [9] has been considered as an approach to amend clinical care for patients [10].

Patient involvement in health – related decisions has been shown to improve patients' understanding of the available treatment options, increase the patient's realistic expectations of health benefits and harms, and improve agreement between patients' values, preferences and treatment choices [4,5,10].

The literature was consistent in that most patients had positive attitudes regarding their desire for active involvement in the health care decisions [11-14]. However, authors in a research study [6] conducted a cross-sectional survey and interviews to explore the gap between HCPs and patients on patient engagement in Hong Kong hospital. Telephone interviews with 2774 HCPs and 1042 patients were performed. Study results revealed that there was a discrepancy of understanding and experiences of both groups. The patients perceived their engagement in health care decisions to a significantly lower degree compared with that reported by doctors and nurses [6]. Further, another study [15] revealed inconsistent results that might be attributed to barriers facing those patients which in turn hindered their active involvement in the decisions related to health issues. The incongruence of perceptions regarding the involvement in D.M between patients and HCPs leads to the decision be taken by HCPs rather than the patients themselves [15].

Patients need both knowledge and power to be participants in SDM. Information alone is not sufficient; it needs to be provided within an organization that supports information sharing and equal relationships between patients and HCPs [9,11]. Meanwhile, many factors can act as barriers for HCPs to explore and respond to patients' preferences regarding the involvement with decisions. They are related to either patients / families, HCPs or to the health organization [16-19].

Till now there is no research in Jordan on both cardiac patients and HCPs experiences regarding involvement in health care D.M. Exploring their views regarding PI in health care decisions can improve our understanding of how patient involvement affects their work and behavior in all phases of hospitalization [18]. Therefore, this study was conducted to explore the subjective experiences lived by cardiac patients and HCPs in Jordan. It can provide insight to the needs of each group and pin point the gap between the needs of patients and perceptions of HCPs.

## **Methods**

This study followed a qualitative approach of Phenomenology developed by Edmund Husserl (1859- 1938). It presents the framework for discovering what it is like to live an experience [20]. It can help in understanding people's subjective experiences through a humanistic philosophy that is valuable to HCPs specially, nursing [20-22].

### **Participants' Selection**

Participants were recruited based on a purposive sampling and were selected according to specific inclusion criteria; 1) Patients who consented to perform, or who underwent any surgical intervention, 2) willing to participate in the study, 3) conscious, without mental illnesses, 4) able to communicate verbally and able to speak and understand Arabic language ,5) with ages of more than 18 years old [23,11]. Regarding HCPs (physicians and registered nurses) those who were available with at least one-year experience working with cardiac patients at the targeted military institution.

### **Recruitment Strategies**

The researcher was introduced to the potential participant as identified by the head nurse in the target institution. They invited the potential participant to participate in the study. The researcher further explained her interest in learning more about the experience of participants. Then the researcher agreed on an interview date, time, and place with each participant. The total number of participants was [41]; 16 patients, 15 nurses and 10 physicians. Researcher was able to achieve saturation with this group of participants over specific period of time.

### **Interview and Setting**

Participants chose the location of their interviews. All patients preferred to be met in their private room in the hospital, while HCPs were met in the conference room of the hospital upon their preferences.

In the current study data was collected by in-depth, individual semi-structured face to face interview. All interviews were conducted by the primary researcher in Arabic language. Such interview allows the interviewer to pose a broad question and then guide participants by probes to describe their experiences. Researcher used introductory statements followed by grand tour question as: 'Can you tell me about how you are living this experience regarding involvement in health care D.M?'

Probing techniques were used to elicit more explanation, such as: "Please tell me more about it?. What does that mean to you? ." This type of questions fit the format used in phenomenological interviewing. The interviews were audio taped and transcribed verbatim. The duration of each interview varied among participants and didn't exceed one hour.

An interview guide was developed by the researcher based on involvement in decision making - related literature (Appendix D). This guide was approved by the scientific committee members

---

(three expert nurses). A demographic sheet form was completed at the end of each interview (Appendix c).

### **Ethics**

Approval to conduct the study was obtained from the institutional review board at the RMS. Each participant was assured that his/her responses would be confidential, and his/her participation was on a voluntary basis. Each participant was asked to read and sign a consent form (Appendix B). Each participant was asked for a permission to use tape record during interviews. Each participant was given a code such as: (B1, C1, A1) to ensure anonymity and confidentiality.

### **Rigor**

Steps suggested by [24], were utilized to ensure rigor of study methods. Credibility was met by triangulation for data collection method, peer debriefing, and member checks. Transferability was assured by the use of thick description from the participants' interviews. Dependability and conformability were addressed by doing intercoder reliability as recommended by Creswell, (2013). The researcher conducted and transcribed interviews, applied qualitative methods to the interview content, and elicited themes. Themes of a second assistant researcher were then compared with the elicited themes for deep understanding. The agreement between the two researchers approached 88%; the remaining themes were discussed, and incongruent findings were resolved.

### **Analysis**

Data were analyzed using a five-step approach of Amedeo Giorgi's phenomenological philosophy [25,26]. Analysis of the data began in line with the first interview. Each taped interview was repeatedly reviewed and read, then transcriptions were organized into codes, categories and themes. Excerpts that reflected the emerging themes were extracted. After analyzing each interview, one of the researchers asked each participant to reflect on the analysis. Participants' comments and reflections were then integrated into the description.

### **Results**

Table 1 and Table 2 Illustrates demographic details of the participating patients and the participating HCPs respectively (Appendix A).

Four major themes were identified, that presents the lived experience of participants. 1) The approach used by HCPs in communicating with patients is comforting, 2) Information provided to patients is helpful, 3) patients preferences regarding D.M style vary., 4) Sociocultural influence and religious factors influence patient's role in D.M.

#### **The approach used by HCPs in communicating with patients is comforting**

Most patients experienced comfortable approach from HCPs; they appreciated their verbal and non-verbal communication and felt it improved their morale. One male patient expressed his comfort with HCPs polite approach, saying:

*Yes, yes, they (HCPs) care, when a nurse approaches you with a smile on his face and addresses you by: "my uncle" and gives you treatment, of course this raises one's moral very much.*

A young male patient's own words indicated his comfort and positive experience with HCPs approach that assisted him to decide on cardiac catheterization:

*I faced an approach, as you can say, they talk to me in a kind manner or something psychologically comforting, so if I feel afraid to do the operation as I view it a big deal, they (HCPs) by their approach comfort and motivate me to decide to go ahead and do it.*

On the other hand, some patients indicated that they do not ask questions due to some factors, as they do not know their physician. This forced some patients to limit their involvement in D.M as they don't know whom to ask. One male patient admitted that he doesn't know his Dr. and said: *"I didn't see my Dr. and I don't know who is he and who to ask questions. He added: "I do not know who will do the operation for me"*

Some patients indicated that uncomfortable communication with HCPs prevented them from talking or speaking up therefore, they don't feel being involved in health care decision. A male patient stated: *"If you ask the first question, some HCPs answer you in a way to close the conversation, so you keep silent"*.

In agreement with some patients views, some specialists described their experiences in limiting the communication with their patients; A male specialist physician was confident in saying : *"Up to my conviction if I was confident that the patient got the information, then I stop him from asking more questions since some patients prefer to talk repetitively so I do not offer them time"*

#### **Information provided to patients is helpful.**

A young male patient described his interesting experience with HCPs in providing him information and said that HCP fully informed and explain to him his health problem and that he felt interested in asking him questions: *" They (HCPs) informed me that surgery is the only option for my case; no other alternative. As I am not educated, he (my Dr.) taught and explained to me and then I got the interest with him in asking questions"*.

In agreement with those patients' views, the majority of HCPs stated that they use more than one way to deal with patient's health problems. Some of those HCPs, declared that they help patients to take a decision by offering them more than one option to solve their problems. A female physician said:

*Of course, we inform the patient that there is more than one way to solve his health problem. So, he is able to take a decision.*

However, few HCPs (one RN and one physician) commented that they do not consider patient preferred approach in providing information due to limited time and workload. Other physicians believed that patients talk and ask a lot, so they will obtain what they want to know: *"People here (in Jordan) insist to ask, if they did not understand they insist to ask"*

---

*People here in Jordan, ask a lot, they prefer to know everything, they talk a lot, so if a patient did not understand any point (information) he will continue asking until he gets an answer.*

Some patients, interestingly find excuses to physicians for not giving them time to question as they perceived that they are too busy and have limited time to talk with and see their patients. One of those patients expressed his sympathetic feelings with physicians, he said:

*Frankly, God help them (Dr.) they do not have time; we overwhelm them and call for them. I see my Dr. once or twice because he (my Dr.) is not free to explain to me, he has no time.*

Four patients shared the experience of being unable to understand their health issues. They felt not willing to engage in such specialized medical information. An old male patient who was scheduled for heart surgery stated that he does not know what will be done during the surgery:

*I know nothing about medicine or medical issues. I do not know what will be done during the surgery. The surgeon knows, it is his job.*

*He added: As patients, we understand nothing in medicine, we do not interfere with medical and technical issues. medicine is the concern of medical staff.*

The three groups of participants, (HCPs and patients) agreed that information is conveyed to patients either directly or through his/her family members (FMs). They agreed that the family has and should have an important role. An expert female RN addressed the importance of family role in providing information to patients, she said:

*"More than one person can convey information to patients and the patient's family plays a key role in that"*

A resident male physician shared RNs and patients views in that point and asserted that in some situations when patients are unable to understand the situation, he becomes obligated to talk to the patient family and involve them in the decision:

*Sometimes, when the patient does not understand, I turn to his wife, son... who understand me and convey the message to the patient in a way he understands.*

Nurses perceive that in our society most patients trust physicians' opinion and listen to them more than nurses. Two RNs agreed that patients put full trust in physicians; A female RN expressed that patients here in Jordan accept physicians' words (information) more than nurses' words. She declared: *"In our society our patients do not accept my word as a nurse. Information it is well accepted if it comes from specialists."*

On the other hand, few RNs expressed positive experience in providing patients required information. They indicated that they provide some options to their patients and share with them information and opinions. One of those nurses, who holds a master degree in nursing reported that:

*"Yes, I offer options to my patients and I may provide them information according to their case and upon their request"*

### **Patients preferences regarding involvement in D.M style vary**

The majority of patients preferred an active role in health care decisions, but they often do not experience such a role in making their decisions. They rarely have their preferences met by their HCPs. An old male patient expressed that he sometimes fails to decide on health interventions as open-heart surgery although he expressed a desire to share with HCPs in making the decision, he said:

*Wallah (really), sometimes I have no say in the decision. Frankly, one prefers to be part in the decision- making process; his life, soul and health are precious to him. I mean I would like to have some independence and to share in the decision with all my due respect to the doctors' opinions (their opinion is on my eye and head) as they are experts, but I prefer to have an opinion because my health worthwhile to me.*

Some patients were not pleased being excluded from decision making concerning the management of their care. They indicated that they have no say in whatever decision is made to treat them.

A male patient expressed that he was surprised by the unexpected decision from his physicians and indicated that they decided everything related to his operation without his involvement. He said:

*They told me: you will have an operation on Monday. We (physicians) met and made a decision. They surprised me; .... They did not ask me but they decided and they did not even inform me about its complications.*

Around two third of patients, mainly males, indicated their utmost trust in their doctors and how being informed about the risks/benefits rate helped them in accepting their doctor's decision of the intended intervention. Mostly what helped them and motivated them to agree was being informed that the operation has a high success rate. A male patient explained:

*"I agree with whatever my doctors see appropriate. The doctor informed me that my operation has 90% success rate, this success rate encouraged me to take the decision to undergo the operation. We depend on Allah after all."*

Some patients were content with HCPs decisions and were satisfied with just being informed and counseled. Those patients felt involved in health care decision only because HCPs discussed with them their condition. Some of them further reflected that they prefer not to be part of the decision but only to know everything about their condition. A female patient said:

*Health care providers do what is appropriate for my condition. but I would like to know everything.*

Only two patients (one male and one female) put unconditional and full trust in HCPs to the extreme that they did not seek or mention a need to be informed. They preferred a passive role in the decision-making process. One of them stated that:

*"I am not a doctor to know all about my condition, they are doctors and they know more than I do"*

---

Most HCPs were consistent in their experiences regarding patients trust in HCPs decisions. For example, an expert male RN stated that about 99% of patients let HCPs take the decision. In addition, another male RN described his experience with patients as totally dependent on HCP particularly on physicians:

*Most patients put their illness loads on their physician, they usually say to their doctors; what is the appropriate? You know better, you knit and we wear.*

Another male specialist physician said:

*"Around 5-10% of patients say to their physician you know my case more than me".*

### **Sociocultural Influence and Religious factors influence patients' role in D.M**

Patients perceived that Involvement in D.M has been influenced by various sociocultural factors and religious issues. Such influences include social support or social pressure, culture and beliefs, as well as certain religious rituals. A married female patient indicated her inability to take her own decision. She believes in her extended family role in making the decision, and said:

*"My brothers, family, sisters and sons have a role in the decision (on my operation). I cannot impose my opinion on my sons and family".*

As an HCP, an expert female RN perceived that cultural factors influence patients' involvement in health care decision, she perceived that some patients value their relative's involvement in their health decision:

*"Relatives can influence patients' decision. For example, a wife may not be able to have a say unless she takes the approval from her husband; she may look at him waiting his agreement. Or the husband may look at her (means to wait for his agreement or disagreement). For old patients, one may look at his son to take the approval on his health decision".*

Some HCPs believed that patients have the right to know their health conditions. However, they indicated that, sometimes, family members try to conceal such conditions from the patient, which might negatively influence his health. A specialist male physician highlighted the family beliefs in that patients should not know about their diseases. He declared that:

*"In general, patients' family and relatives sometimes do not prefer their patients to know all about their health, so one tells us, for example this father does not know about his health condition. He may say that if his father knew about his disease he may pass away".*

Some patients believe completely in Allah which in turn influences their decision. A male RN expressed his experience with such patients and stated that patient's culture and beliefs may limit their sharing with HCPs in making a decision.

For example, some high risky patients experienced a contradicting decision with that of their physicians:

*"One patient insisted on his decision to do an operation in spite of its high risk, he perceived that life is in Allah hands"*

### **Discussions of Results**

The purpose of this phenomenological study was to describe the experiences of cardiac patients and HCPs regarding the involvement of patients in health care decisions.

#### **Theme one: The approach used by HCPs in communicating with patients is comforting**

Patient- centered communication is the most effective way in consultations. An understanding of patients' individual needs, perspectives and values, it will yield the information needed and builds trust and understanding for both patients and HCPs [4,12,27].

Previous studies [4,15,28,29] confirmed the findings of this study, as patients felt involved through experiencing supportive and comfortable communication despite not being actively involved in decision-making. This emphasizes the use of supportive communication and equal partnership to create an environment for active patient involvement.

Findings from this study were found to be contradicting to the findings of similar studies [6,28]. They indicated that patients experienced an asymmetric power relationship with HCPs that hindered their expressions of personal autonomy through individual choice. In this study, one young male patient expressed his comfort in communicating with a busy, high military rank physician who offered him an open channel of communication. Patients felt involved when they sensed that physicians facilitated mutual understanding between them. This emphasizes on the importance of decreasing the unbalanced power in supporting patient autonomy through shared D.M process.

#### **Theme Two: Information provided to patients is helpful**

Providing information, including offering options and clarifying pros and cons of the needed intervention, facilitate patients' understandings and motivate them to be actively involved in D.M [4,12,17,30,31]. It has been evident in this study that patients considered gaining information about health condition is prerequisite to be actively involved in health care decision.

In this study, seven patients were not well- informed about their health conditions. Some of those patients experienced passive role as they lacked the needed information and treatment alternatives. Similar responses were expressed by patients in previous studies [12,17,30] as patients perceived passive role in D.M due to poor knowledge. This consistency of findings asserts that patient's awareness and understanding are crucial for being actively involved in health care decisions. Interestingly, patients with passive role preferences, feel involved in D.M when they just seek information, believing that information gained enable them to talk more and tell their story confidently to their HCPs [12,29,32].

---

Limited opportunity for interaction indicates little PI. Participants in this study are treated in public health sector where the time limits, and heavy work load are clearly visible. The medical model of care is dominant in the public health care sector. Military health institutions in Jordan reflect this model of care as evident by the structural style of leadership and military ranks. Therefore, the provided care at the public health sector is physician-centered rather than patient-centered and patients are not given enough information about treatment alternatives and the disease [17]. Health organization policies should consider the limited time and high workload in the public health care sector.

Language used by HCPs in providing information is prominent factor affecting the level of involvement of patients in D.M process [14]. It was indicated by several studies that HCPs in general are accustomed to use medical terms in their encounters with patients and their families; this language may hinder patients/family's involvement to share decisions with them [4,14,32]. Similarly, some patients and HCPs in this study expressed that considering patient's preferred approach to receiving information depends mainly on patients LOE, patient-HCPs interaction and their responses to this interaction. Three patients shared the experience of being unable to understand their health issues indicating that they are complicated and difficult to be absorbed. These findings were supported by similar studies [4,12,33] on this topic.

It has been evident in the literature that lacking information and support puts individuals at increased risk for psychological distress, reduced sense of well-being, and dissatisfaction with care [17]. Since the final decision based on the incomplete information they were offered [31].

Patients in this study, perceived that asking questions was not a part of their expected role. They perceived that HCPs know their duties and responsibilities. Therefore, they reported their full trust in and deference to HCPs recommendations specially Physicians, which was consistent with some studies [6,19,31].

Few RNs, with high education degree expressed positive experience in providing information. Patients may be more likely to accept and receive information from nurses with higher education level. Some patients do not consider it appropriate to ask questions at all, feeling that this is may be viewed as a lack of trust in the HCPs [19], patients fear of being categorized as a difficult patient. So, they do not challenge HCPs through asking them questions [6].

### **Theme Three: Patients Preferences regarding D.M style vary**

Consideration given to patient's preferences in providing health care is vital to improve the patients' satisfaction as well as health outcomes [12,14,34,35]. The majority of patients in this study, had positive attitudes in regard to be involved in D.M process. Meanwhile, they experienced feelings of involvement through acquiring knowledge about their disease and its treatment. These experiences were congruent with the literature [11,17,29,30] on this topic.

In the current study, it is evident that most of the patients tend to rely on HCP's decisions, mainly on physicians. One previous study [11] confirmed the findings of this study in which the obedient pattern was the most common pattern among cardiac patients. This pattern reflects the passive role of their involvement in the healthcare decisions. Possible explanation to such findings is related to the paternalistic model of medical practice which still dominant in many public healthcare sectors in Jordan, which might have played a role in the patients' preferences. Jordanians, still view physicians as having the ultimate control over specialized health knowledge [36].

Other patients, in this study preferred to share and discuss health information with HCPs and then they let them decide. This reflects patient's perception of being involved in health care decision through sharing in information rather than sharing in decision-making process. Findings of this study confirmed the findings of other studies [37-40]. In which they found that cardiac patients are often misinformed about their health conditions and treatments. Therefore, they have little or no involvement in health care decisions. Similarly, authors [32] found that people did not want to bear their decisions' responsibility but had strong interest in being informed.

Experiencing the preferred style is associated with some factors. Findings from the available literature revealed factors such as patients' economic status in one study [19] and HCPs-patients therapeutic relationship in others [41,40].

### **Sociocultural and Religious factors influence patients' role in D.M:**

Within different societies, the experience of PI in health care decisions is influenced by social, cultural, and religious morals. Findings from this study supported the previous studies [17,36,42,43] on this topic. In Jordan, Family support was prominent in this study and was highly appreciated by patients, particularly females [36].

In this study, patients trusting family members was strongly prominent. Authors in previous studies [36,30] confirmed the findings of this study as most of the patients relied on their immediate FMs to educate them about their health conditions, because some of their FMs were well educated in the health field. This emphasized the importance of family involvement in health care decisions. Patients in this study particularly females experienced failure to make their own decision without involving their FMs. Married female patients often concerned with their husbands' opinion to make the final decision, while old ages considered their sons as key elements in decision involvement. This is similar to what authors [44] found in this regard, that FMs can have a more dominant role during the decision-making.

In this study, some HCPs asserted that when patients were unable to understand the situation (e.g illiterate, and emergency cases) they became obligated to involve patients' family. Moreover, HCPs in this study reported that some family members asked them for concealing health information from their patients. They

---

perceived that informing the patient himself might deteriorate his health condition. These findings were similar to findings in the reviewed literature [17,31,44].

It is evident in the literature that physicians tend to communicate disease-related information to family caregivers, rather than to patients themselves. Literature [17,30,31,43,45] confirmed the findings of this study as some physicians admitted that they did not provide full information to their patients. They communicate health information first to patients' family mainly their sons. Physicians in other different cultures perceived the same experience as in countries such as Egypt, Italy, and Japan [43].

A possible explanation of that experience is that physicians assumed that patients preferred not to receive this news. Further, disclosure of detailed information may lead patients to disappointment and despair [17].

During illness, religious and spiritual beliefs as a strategy of coping is well documented in the literature [17,30,36,42]. In this study, patients frequently displayed spirituality and religiosity by acknowledging "Allah" for their wellness and illness. Authors in one previous study [42] concluded that spirituality was viewed as a source of comfort; it reduced patients' fear and uncertainty and gave them the strength to tolerate the treatment.

In this study, some patients with high risky conditions experienced a contradicting decision with that of physicians. They decided to perform the operation against medical advice believing that life is in Allah hands.

This study confirmed the findings of previous one [36] in which, to control their fear, patients unconditionally trusted Allah and often accepted options offered by their HCPs without questioning. In this study, many of patients held the belief that disease comes from Allah. Death and life are determined by Allah. As Islamic culture is rooted among Jordanians; this belief was originated from Islamic teachings that Muslims should accept good and bad fate, thanking Allah for both, and leaving the final results on Allah.

### **Implications for the Study Findings**

The findings of the present study may help in understanding patients and HCPs' subjective experience in regard to involvement in health care decisions. This can be beneficial to understand the discrepancies and commonalities of patients and HCPs perceptions regarding the involvement in health care decisions. The findings from this study indicated that preferred style of D.M had impacted the level on PI. Patients in this context had faced some factors/barriers to be actively involved in D.M. It was evident that certain sociocultural influences and beliefs may have had influenced participants' experiences that could be an area for nurses to reinforce the positives and modify the undesirable ones. Religiosity was also found to play a role during this experience. Further, social support through family role in health care decisions had influenced patients experience regarding their involvement in their decisions. This exploration, has important implications for

nursing education, nursing research, practice and policymakers.

### **Limitations of the Study**

The researcher was challenged by the dual role as a nurse and as a researcher. The phenomena under study required good recall of the events that happened in the past. Good recall may challenge the researcher and the participants. Some HCPs who were interviewed, were overloaded from the high number of patients per shift which caused some interruptions during interviews. Such interruptions could impact the continuity of participants' thoughts and the researcher's as well.

Further, culture of the Jordanian participants was apparent in this study. It may limit the transferability of these study findings to other cultures. Descriptive phenomenology approach limited the researcher to only describe participants experiences without interpretation or elaboration on those experiences. There was no alternative meeting room to conduct the interviews with participants.

### **Recommendations for Future Research**

Experiences of patients, families and HCPs from different health care settings and other cultures, may need to be explored. This might be significant to investigate how different health settings and cultural backgrounds influence patients and HCPs experiences of involvement in D.M process. Different context regarding data collection time such as post patients discharge from the hospital may reveal significant findings. Lastly, interpretive data analysis is recommended.

### **Conclusion**

This study examined the experiences of cardiac patients and HCPs regarding involvement in health care decisions. Generally, participants in this study, have positive attitudes toward active involvement in health care decisions. Most patients preferred to rely on HCPs, mainly physicians to take the final decision. Their preferences were influenced by HCPs' perceptions and communication, sociocultural and spiritual factors, as well as their health status. The differences in D.M styles preferences should be considered and recognized to carry out patient's involvement that is consistent to their values for best outcomes.

### **Acknowledgments**

The support of Royal Medical Services (RMS) directorate in recruiting participants and Prof. Fathieh Abu Moghli genuine work is greatly appreciated. Great appreciation to the Master holder in English translation, Shajan yousef who edited the work and authenticated the translation process. Special thanks to the participants who shared their personal experience with us.

### **References**

1. Ahmed M, Safadi E. Decisional involvement among Nurses Governmental versus Private Hospitals. Health Science Journal. 2013; 7: 18-27.
2. Desroches S, Gagnon M, Tapp S, et al. Implementing shared

- decision-making in nutrition clinical practice A theory-based approach and feasibility study. *Implementation Science*. 2008; 3: 48.
3. Charis A, Witteman H, Whyte S, et al. Questioning context a set of interdisciplinary questions for investigating contextual factors affecting health decision making. *Health Expectations*. 2010; 14: 115-132.
  4. Siouta E, Hedberg B, Muhli U, et al. Patients' experiences of communication and involvement in decision making about atrial fibrillation treatment in consultations with nurses and physicians. *Scand J Caring Sci*. 2015; 30: 535-546.
  5. Arnetz J, Zhdanova L. Patient involvement climate: views and behaviours among registered nurses in myocardial infarction care- *Journal of Clinical Nursing*. 2014; 24: 475-485.
  6. Wong ELY, Lui S, Cheung AWL, et al. Views and Experience on Patient Engagement in Healthcare Professionals and Patients How Are They Different. *Open Journal of Nursing*. 2017; 7: 615-629.
  7. Crispin V, Bugge C, Stoddart K. Sufficiency and relevance of information for inpatients in general ward settings A qualitative exploration of information exchange between patients and nurses. *International Journal of Nursing Studies*. 2017; 75: 112-122.
  8. Khuan L, Hanafiah Juni M. Nurses' Opinions of Patient Involvement in Relation to Patient-centered Care During Bedside Handovers *Asian Nursing Research*. 2017; 11: 216-222.
  9. Pryce H, Hall A. The Role of Shared Decision-Making in Audiologic Rehabilitation not reported Quality Assurance Department, face to face interview. 2012.
  10. Lin G, Fagerlin A. Shared Decision Making State of the Science. *Circ Cardiovasc Qual Outcomes*. 2014; 7: 328-334.
  11. Olsson K, slund U, Nilsson J, et al. Patients' Decision Making About Undergoing Trans catheter Aortic Valve Implantation for Severe Aortic Stenosis. *Journal of Cardiovascular Nursing*. 2014; 31: 523-528.
  12. Ernest A. Shared Decision Making Engaging Patients to Improve Health Care. by Families USA. 2013.
  13. Al Ananbeh E, Abu-Moghli F, Khalaf I. perception and experiences of nurses regarding patients involvement in health care decisions: an integrative review. *International Journal of Applied and Natural Sciences*. 2018; 7: 99-110.
  14. AlHaqwi A, AlDrees T, AlRumayyan A, et al. Shared clinical decision making A Saudi Arabian perspective. *Saudi Med J*. 2015; 36: 1472-1476.
  15. Dierckx K, Deveugele M, Roosen P, et al. Implementation of shared decision making in physical therapy: observed level of involvement and patient preference. *Phys Ther*. 2013; 93: 1321-1330.
  16. Charles C, Whelan T, Gafni A. What do we mean by partnership in making decisions about treatment. *BMJ*. 1999; 319: 780-782.
  17. Obeidat R, Khrais HI. Jordanian Physicians' Attitudes toward Disclosure of Cancer Information and Patient Participation in Treatment Decision-making. *Asia-Pacific Journal of Oncology Nursing*. 2016; 3: 281-288.
  18. Protheroe J, Brooks H, Chew Graham C, et al. Permission to participate A qualitative study of participation in patients from differing socio-economic backgrounds. *Journal of Health Psychology*. 2012; 1-10.
  19. Ahmed M, Safadi E. Decisional involvement among Nurses: Governmental versus Private Hospitals. *Health Science Journal*. 2013; 7: 18-27.
  20. Streubert H, Carpenter D. *Qualitative research in nursing: Advancing the Humanistic imperative* 5th edition. Lippincott Williams and Wilkins. Philadelphia. 2011.
  21. Polit DF, Beck CT. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. 5<sup>th</sup> ed. Philadelphia, Lippincott Williams & Wilkins. 2012.
  22. Creswell J. *Research design: qualitative, quantitative, and mixed methods approaches* 3rd Ed. Thousand Oaks, CA. Sage Publications Inc. 2013.
  23. Yasein N, Shakhathreh F, Shroukh W, et al. Comparison between Patients' and Residents Perceptions of Patient Centeredness and Communication Skills among Physicians Working at Jordan University Hospital. *Open Journal of Nursing*. 2017; 7: 698-706.
  24. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*. 2004; 22: 63-75.
  25. Giorgi A. Phenomenological Philosophy as the Basis for a Human Scientific Psychology. *The Humanistic Psychologist*. 2014; 42: 233-248.
  26. Castro A. Introduction to Giorgi's Existential Phenomenological Research Method. *Psicologadesde el Caribe. Uoiversidad del None*. 11: 45-56.
  27. Vahdat S, Hamzehgardeshi L, Hessam S, et al. Patient Involvement in Health Care Decision Making: A Review. *Iran Red Cres Med J*. 2014; 16: e12454.
  28. Gainer RA, Curran J, Buth KJ, et al. Toward Optimal Decision Making among Vulnerable Patients Referred for Cardiac Surgery: A Qualitative Analysis of Patient and Provider Perspectives. *Med Decis Making*. 2017; 37: 600-610.
  29. Barstow C, Shahan B, Roberts M. Evaluating Medical Decision-Making Capacity in Practice. *Am Fam Physician*. 2018; 98: 40-46.
  30. Sekimoto M, Asai A, Ohnishi M, et al. Patients' preferences for involvement in treatment decision making in Japan. *BMC Fam Pract*. 2004; 5: 1.
  31. Obeidat R, Lally R. Health-Related Information Exchange Experiences of Jordanian Women at Breast Cancer Diagnosis. *J Canc Educ*. 2014; 29: 548-554.
  32. Dorthea C, Dorthea W. Patients preferences for involvement in clinical decision-making within secondary care and the factors that influence their preferences *Journal of Nursing Management*. 2005; 13: 119-127.
  33. Speziale HJ, Carpenter DR. *Qualitative research in nursing:*



- 
- Advancing the humanistic imperative 4th Ed. Philadelphia Lippincott Williams & Wilkins. 2007.
34. Nalley C. Shared Decision-making. Understanding Patient Preference. Society of Gynecologic Oncology's SGO, Annual Meeting on Women's Cancer Abstract 47 EDITORIAL. *Oncology-Times.Com*. 2017; 16-17.
  35. Jasinski M, Lumley M, Mandel S. Patient factors in decision-making for orthopaedic surgery: a prospective analysis. *Current Orthopaedic Practice*. 2017; 28.
  36. Obeidat R, Dickerson S, Homish G, et al. Controlling Fear. *Cancer Nursing TM*. 2013; 36.
  37. Michael J, Barry Susan Edgman Levitan, N Engl J. Shared Decision Making The Pinnacle of Patient-Centered Care. *England journal of medicine Engl J Med*. 2012; 366: 780-778.
  38. O'Connor A, Llewellyn-Thomas H, Flood A. Modifying Unwarranted Variations in Health Care: Shared Decision Making Using Patient Decision Aids. A review of the evidence base for shared decision making. *Health Affairs*. 2004.
  39. Stacey D, Légaré F, Ratté S, et al. Interventions for improving the adoption of shared decision making by healthcare professionals. *Cochrane Database of Systematic Reviews*. 2010; 12: CD006732.
  40. Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter What does it mean. or it takes at least two to tango. *Soc Sci Med*. 1997; 44: 681-692.
  41. Murray E, Pollack L, White M Lo B. Clinical decision-making: physicians' preferences and experiences. *Patient Educ Couns*. 2007; 65: 189-196.
  42. Banning M, Faisal S, Hassan M, et al. The Impact of Culture and Sociological and Psychological Issues on Muslim Patients with Breast Cancer in Pakistan *Cancer Nursing TM*, 2009; 32: 317-324.
  43. Doumit M, Huijjer H, Kelley J, et al. The Lived Experience of Lebanese Family Caregivers of Cancer Patients *Cancer Nursing*. 2008; 31.
  44. Lamore Kristopher, Montale scot Lucile, Untas Aur'elie. Treatment decision-making in chronic diseases: What are the family members' roles, needs and attitudes? A systematic review. *Patient Education and Counseling*. 2017.
  45. Taha H, Al Qutob R, Nyström L, et al. Voices of fear and safety. Women's ambivalence towards breast cancer and breast health a qualitative study from Jordan. *BMC Women's Health*. 2012; 12: 21.

## Appendix A

Patients characteristics	Number (16)	(%)
<b>1-Age</b>		
18-28	None	
29-39	2	12.5
40-50	2	12.5
50 and above	12	75
<b>2-Gender</b>		
Male	10	62.5
female	6	37.5
<b>Marital status</b>		
Married	14	87.5
Single	None	----
Divorced	None	----
Widow	2	12.5
Others	None.	
<b>3-Level of education</b>		
Less than (high school) Tawjihi.	9	56.25
High school.	5	31.25
More than high school.	2	12.50
<b>Medical diagnosis</b>		
For operation:		
Cardiac Cath	1	6.25
Cardiac Stent	1	6.25
Open heart	6	37.5
Post operation	8	50
<b>Co-morbidity</b>		
DM	9	56.25
HTN	8	50
DM & HTN	7	43.75
Hyperlipidemia	3	18.75
Others	6	37.50
<b>Employment</b>		
Employed	7	43.75
Not Employment	9	56.25
<b>Living conditions</b>		
With family	14	87.5
With spouse	2	12.50
Alone	None	
<b>Insurance type</b>		
Military	8	50
Civilian	5	31.25
Others	3	18.75
<b>Income Average</b>		
<500 JD	6	37.5
>500 JD	10	62.5

**Table 1:** Demographic details of the participating patients.

HCPs characteristics	Physicians (10)		Registered nurses (RNs) (15)	
	Number	(%)	Number	(%)
<b>1-Age</b>				
18-28	5	50	8	53
29-39	4	40	7	47
40-50	1	10	None	
50 and above	None		None	
<b>2-Gender</b>				
Male	8	80	7	46.66
Female	2	20	8	53.33
<b>Marital status</b>				
Married				
Single	6		12	80
Divorced	4	60	3	20
Widow	None	40	None	
Others				
<b>3-Level of education</b>				
Bachelor degree.	10		14	93.33
Higher than Bachelor degree.	None	100	1	6.66
<b>Years of experience</b>				
Less than 5 years	5	50	4	26.66
5 years.	none		1	6.66
More than 5 years	5	50	10	66.66

**Table 2:** Demographic details of the participating HCPs.

