Patient Education and Counseling 88 (2012) 330–337

Contents lists available at SciVerse ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Patient and Provider Perspectives

Patients' and health professionals' views and experiences of atrial fibrillation and oral-anticoagulant therapy: A qualitative meta-synthesis

Christian Borg Xuereb [a,b,*], Rachel L. Shaw [a], Deirdre A. Lane [a,b]

[a] School of Life & Health Sciences, Aston University, Birmingham, UK
[b] University of Birmingham Centre for Cardiovascular Sciences, City Hospital, Birmingham, UK

ARTICLE INFO

Article history:
Received 11 January 2012
Received in revised form 18 April 2012
Accepted 18 May 2012

Keywords:
Meta-synthesis
Qualitative Research
Patient
Doctor
Experiences
Atrial fibrillation
Oral-anticoagulation therapy

ABSTRACT

Objective: Atrial fibrillation (AF) patients are prescribed oral-anticoagulant (OAC) therapy, often warfarin, to reduce stroke risk. We explored existing qualitative evidence about patients' and health professionals' experiences of OAC therapy.
Methods: Systematic searches of eight bibliographic databases were conducted. Quality was appraised using the Critical Appraisal Skills Programme tool and data from ten studies were synthesised qualitatively.
Results: Four third-order constructs, emerged from the final step in the analysis process: (1) diagnosing AF and the communication of information, (2) deciding on OAC therapy, (3) challenges revolving around patient issues, and (4) healthcare challenges. Synthesis uncovered perspectives that could not be achieved through individual studies.
Conclusion: Physicians' and patients' experiences present a dichotomy of opinion on decision-making, which requires further exploration and changes in practice. Outcomes of workload pressure on both health professionals and patients should be investigated. The need for on-going support and education to patients and physicians is critical to achieve best practice and treatment adherence.
Practice implications: Such research could encourage health professionals to understand and attend better to the needs and concerns of the patient. Additionally these findings can be used to inform researchers and healthcare providers in developing educational interventions with both patients and health professionals.

Contents

* Corresponding author at: School of Life & Health Sciences, Aston University, Birmingham B4 7ET, UK. Tel.: +44 121 204 4050; fax: +44 121 204 4090.
E-mail addresses: c.borg-xuereb@nhs.net, chrisborgxuereb@yahoo.co.uk (C. Borg Xuereb).

0738-3991/$ – see front matter © 2012 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.pec.2012.05.011

1. Introduction

Atrial fibrillation (AF) is the most common arrhythmia in clinical practice and is associated with increased morbidity and mortality [1,2]. AF is an independent risk factor for stroke conferring a risk five times that of matched controls [3]. Hence, stroke risk reduction with antithrombotic therapy is a crucial component of AF management [2,4]. Guidelines recommend life-long oral-anticoagulation (OAC) therapy for patients with one or more risk factors for stroke [2]. However, such therapy remains underutilised [5,6].

There are a number of complex factors which make prescription, and adherence, of OAC challenging. Physicians may display uncertainty about balancing the risk of stroke and the risk of bleeding, which may be passed onto patients [7]. Two recent systematic reviews emphasised the impact of physicians' apprehension about feeling responsible for a major bleed which seemed to outweigh their concern about risk of stroke [8,9]. This may be related to the Hippocratic Oath to 'first do no harm' [10]: responsibility is attributed to harm perceived to be caused by 'acts of commission', i.e. prescribing OAC, which are not felt with 'acts of omission', i.e. increasing the risk of stroke by not prescribing OAC.

Very little is known about patients' understanding of AF and OAC treatment. What we do know is that patients with AF report poorer quality of life compared to the general population [4,11], and greater levels of anxiety [12].

This meta-synthesis will address the need to consolidate existing evidence about patients' and physicians' experience of AF and OAC. The complexity inherent in this field make the need for patient-centred care, effective communication skills, and individually tailored education, as recommended by the National Institute for Health and Clinical Excellence (NICE) [1], particularly significant. The benefit of incorporating qualitative evidence like that presented in this meta-synthesis within the larger hierarchy of evidence is that it can add depth; it can bring the focus back to the individual to ensure that population-based findings retain their applicability to the individual case [13]. Consequently a meta-synthesis of qualitative evidence examining patients' and health professionals' experiences and beliefs about AF and OAC therapy was conducted to determine what is already known, implications for practice and to indicate where further research should be focused.

2. Method

Meta-synthesis of qualitative evidence is modelled on traditional systematic review methodology [14] and this meta-synthesis follows the techniques described in Taylor et al. [15]. A systematic search strategy, screening and quality appraisal were employed. Search terms were developed from two main bibliographic database categories: 'atrial fibrillation' and 'anticoagulant therapy'; a qualitative methodology filter was used to ensure the retrieval of qualitative studies [16] (see Appendix A for the full search strategy). Web of Knowledge, Ingenta connect, ScienceDirect (EBSCO), Swetswise, Sage Journals online, PsycInfo and the Cochrane Library were searched to include publications up to 26th August 2011. The UK electronic theses online service (EThOS) and Google scholar were searched to identify UK dissertations and grey literature.

Studies retrieved were screened using the following inclusion criteria: studies that explored views or experiences of patients or carers and/or health professionals (e.g. physicians and/or nurses and/or pharmacists) about AF and/or OAC using qualitative methods (defined as using qualitative techniques for recruitment strategies, data collection, and data analysis). Once screened, duplicates were removed and reference checking and citation searches were conducted. Authors were contacted directly if pertinent data or methodological information such as the method of data analysis used were missing.

The quality of studies was appraised using the Critical Appraisal Skills Programme (CASP) Tool for qualitative research [17], independently by the research team (CBX, RS, DAL), who then met to agree the quality of the studies. Papers were deemed to be of low quality when any or all of the following issues were identified: incomplete description of the methods used, missing qualitative data linking to authors' interpretations and conclusions, and omission of discussion in trustworthiness of study. Papers deemed to be of low quality were not excluded but their findings were given less "weight" during the synthesis process [18].

Synthesis proceeded following the principles outlined by Malpass et al. [19]. Articles were read in-depth and their findings, including the original authors' interpretations and conclusions were recorded in data extraction forms. Key themes and categories were identified (first-order constructs) and grouped through descriptive coding to form second order constructs (see Table 1). The synthesis then involved the interpretative activity of translating studies into each other, i.e. comparing and contrasting themes across papers to identify super-ordinate themes, or third-order constructs, which represent the collective meanings of findings from individual papers to enable a theoretical interpretation of the phenomenon. This whole process was facilitated by the use of mind maps and discussions between the research team (CBX, RS, DAL) to think through interrelations between first- and second-order constructs within and between papers to ensure the development of

Table 1
Examples of first-order constructs and the development of second-order constructs.

First-order constructs		Developing second-order constructs
Lipman et al. [24]	Anderson et al. [26]	
"I like to advise... identify what the patient thinks they need, what I think they should have, and then if it's acceptable we come to an agreement and we try to take it forward, its negotiation, try more and more nowadays to do that in a consultation..." (GP1)	"I would almost put the decision or the ball in his court and I would go down the lines of describing t o him his absolute and relative risk reductions with aspirin and warfarin... and I'd see what he'd prefer to do" (Physician)	The physician's perspective of the decision making process
First-order constructs		Developing second-order constructs
Dantas et al. [22]	Bajorek et al. [25]	
"I can recall that I had no objection. I said, "You are the experts, you are the doctors. If I get any help, I mostly will appreciate it."... I don't think I would trust myself that much (to make the right decision)." (P15)	Nurses believed that patients were generally familiar with what type of medication warfarin was (a 'blood thinner'), although they did not always understand why it was prescribed for them.	The patient's perspective of the decision making process