Patient Demographics Making the Difference: A Qualitative Interview Study on Physicians' Use of Shared Decision Making in Their Consultations

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Master thesis

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August 2023

Abstract

The communication between a physician and patient is a very important element for high quality health care. Part of this communication is shared decision-making, an approach in which treatment related decisions are taken together with the patient. Because of shared decision-making, patients will have better perceptions of the risks of each treatment option and choose the treatment that suites their preferences. shared decision-making has often been studied from a patients' perspective, but to a lesser extent from the physicians' perspective. This study will look at the physicians' view on shared decision-making usage during consultations with a focus on whether patient demographics, such as gender, ethnicity, and socioeconomic status make any difference in the shared decision-making usage. Sixteen in-depth interviews with physicians from different specialisms were conducted. Findings showed that all physicians see shared decision-making as very important. Gender did not play a role in consciously adapting shared decision-making usage, whereas ethnicity and socioeconomic status could make a difference for the physicians. Physicians stated that with non-Dutch or lower socioeconomic status patients shared decision-making was sometimes a challenge due to patients' preferences or other barriers. This study showed the physicians' view on whether the patients' gender would make a difference in shared decision-making usage, which had not been studied yet. Furthermore, this study provided deeper insights in how physicians view their shared decision-making usage for patients with different ethnicities or socioeconomic status.

Keywords: shared decision-making, physician-patient communication, gender, ethnicity, socioeconomic status

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Good physician-patient communication is important because it can help with better treatment adherence and therefore improve clinical outcomes. Treatment adherence is the extent to which the behavior of a patient is consistent with the prescribed behavior in the treatment plan (Dunbar-Jacob & Mortimer-Stephens, 2001). Besides that, physician-patient communication can lead to improved patient satisfaction (Kurtz, 2002; Willems et al., 2005). Communication between a physician and patient serves three functions: enhancing the interpersonal relationship between physician and patient, exchanging information between both parties and shared-decision making (SDM) (Ha & Longnecker, 2010; Ong et al., 1995). SDM is defined as "an approach where clinicians and patients make decisions together using the best available evidence" (Elwyn et al., 2010, p. 1).

SDM was first mentioned in 1984 (Bayer, 1984) and it has been gaining popularity ever since. It is the opposite of the paternalism approach in which the physician would take all the decisions for the patients (Elwyn et al., 2012). With SDM, patients will get more opportunities to express their opinion, values, and feelings (Bomhof-Roordink et al., 2018; Keij et al., 2021). SDM can enhance the engagement of patients as they need to think about (dis)advantages of each treatment option (Elwyn et al., 2010). After discussing cure methods, patients can still indicate that they want the physician to make the final choice (Keij et al., 2021). Most providers and patients seem to be positive towards SDM (Ijaz et al., 2018).

Despite these mostly positive attitudes towards this approach, patients are not always involved in the decision making process. Patient demographics, such as gender, ethnicity, and socioeconomic status (SES) might have an influence on the use and successfulness of SDM (Jolles et al., 2018; Willems et al., 2005). SES is a combination of a persons' economic and social factors, such as years of education and income. Besides that, one's SES is positively linked to one’s health (Baker, 2014). Research has shown that patients from ethnic minorities reported to be less satisfied with the SDM experience than patients from ethnic majorities. Besides that, ethnic minorities participated to a lesser extent in SDM (Jolles et al., 2018, Peek et al., 2010). An explanation can be found in the attitude of ethnic minority patients towards the healthcare system, which is often showing a lack of trust. Moreover, in some cultures is SDM unusual, the physician should take all treatment related decisions. Therefore, some patients might not want to engage in the SDM process (Jolles et al., 2018). Patients from ethnic minorities seem to receive less chances to participate in the decision making process. Ethnic minority patients indicated that physicians were more likely to direct the conversation and less likely to discuss the treatment preferences from the patients (Peek et al., 2010). Another study showed the physicians’ perception on ethnicity, revealing that people with a darker skin were seen as less satisfied with the communication in consultations. Moreover, these patients were seen as less effective communicators (Street et al., 2007).

Another element that may influence the SDM usage from a physician is SES. A systematic review showed that patients with lower SES seem to receive less information and the consultation is more directed by the physician. Physicians misinterpret those patients’ abilities to actively take part in the decision making process and their need for information (Willems et al., 2005). This is possibly due to the fact that physicians sometimes think that people with lower SES might not understand information related to health. Another explanation is that patients with lower SES are perceived as not interested in the information provided by the physician (Richardson et al., 2012). Besides that, how a physician communicates to its patients is dependent on the communication style of the patient. Higher SES patients are communicating more actively and with more affection, which causes the physician to give more information (Willems et al., 2005).

These previously mentioned studies have provided valuable insights on the topic of SDM, its (dis)advantages and usage in relation to various demographics. Research regarding these topics often focus on the patients' experiences (Zill, 2014). Other studies do take the physicians' perspective into account, mainly via observational studies (Georgopoulou et al., 2018). However, there has been too little focus on the physicians' perspective regarding SDM usage during consultations for patients with varying demographics, indicating a gap in the literature. Therefore, this study aims to find out what physicians value regarding SDM and how they think they use SDM during consultations with patients. To get a better insight in their point of views, semi-structured in-depth interviews with physicians were conducted. A better understanding of this topic could lead to improved communication between physicians and patients, because the physicians will be more aware of their way of communication and SDM usage and therefore adapt it if needed. Physician-patient communication has an influence on the outcomes of the consultations, meaning that improved communication can ultimately lead to improved health outcomes for the patients. Therefore, this study aims to explore to what extent gender, ethnicity, and SES influence the view of physicians on using SDM during their consultations.

Theoretical framework

Physician-patient communication can have an influence on health outcomes which is why it should be managed. A part of physician-patient communication is SDM (Ong et al., 1995), which has shown to have many benefits. For example, the patient is better informed about the treatment benefits and risks. Besides that, unnecessary harm from the patients' non-preferred treatment options is avoided (Stiggelbout et al., 2012) However, literature has shown that demographic variables, such as ethnicity, gender and SES can play a role in the physicians' SDM usage. For example, patients of ethnic minorities are at risk of receiving less SDM (DeMeester et al., 2016), just like lower SES patients (Frantsve & Kerns, 2007).

Physician-patient communication

Physician-patient communication is important for, among others, treatment adherence (Ha & Longnecker, 2010), the patients' ability to recall and understand medical information, and the ability to cope with the disease and quality of life (Ong et al., 1995). The patients' perception of the physicians' communication should be as positive as possible, in order for the patients to be satisfied with the medical care. A patients' perception of the treatment is partly determined by the friendliness of the physician. Moreover, the physician taking enough time to discuss social subjects, offering enough information to the patient (Fremon et al., 1971), and being empathic is beneficial for patient outcomes (Zhang et al., 2023). Physicians should avoid some elements in their communication in order not to interfere with the successfulness of the physician-patient communication. These are: excessive use of medical jargon, no or little friendliness and warmth, and not asking for possible concerns and expectations a patient might have (Korsch et al., 1968).

Shared decision making

SDM is becoming more and more common in the healthcare setting as it has many benefits (Elwyn et al., 2012). SDM will help patients to feel more informed about the treatment options (Stiggelbout et al., 2012), so the patients can make a treatment decision that suites their preferences (Stacey, 2017). SDM can also be linked to better treatment adherence. De Las Cuevas et al. (2022) showed that treatment adherence will be higher if there is a match between preference and experience in the decision making process. Better treatment adherence can lead to less hospitalization, less hospital costs and avoid the condition to worsen (Dunbar-Jacob & Mortimer-Stephens, 2001). Moreover, the treatment that is chosen via SDM is often more conservative and has therefore less risks for the patient than in a situation where the physician makes all the decisions (Elwyn et al., 2012).

These benefits match the physicians' attitude on SDM, as physicians are mostly positive about using SDM. Patient involvement in the decision making process was preferred by the physicians as long as the patient was able to understand and recall the discussed information during the consultation to consider the treatment options (Pollard et al., 2015). Despite the physicians' preference for a patients' active role in SDM, physicians reported to only use SDM for just over half of all their patients (Kanzaria et al., 2015).

Nonetheless, not every patient wants or can adequately participate in the decision making process. Keij et al. (2021) identified five factors that indicate a patients' ability to take part actively in SDM. To begin with, the patients' competency to make decisions regarding their health will be influenced by their knowledge of the disease and treatment options. The physician will provide the patients with information and the patients should be able to understand and recall it (Elwyn et al., 2012). This is not always the case, for example when the physician uses medical jargon. That makes it very hard for the patient to understand the information (Korsch et al., 1968). Moreover, a patient should know about their own values and be able to express their opinion, questions and concerns. Furthermore, the patient needs the cognitive ability to consider different treatment options (Keij et al., 2021). Lastly, a patients' self-efficacy, so whether the patient considers themself as being able to participate in deciding about the treatment, will influence the participation in the decision making process (Joseph-Williams et al., 2014).

Besides patients' ability to participate in the decision making process, other obstacles on the practical side can occur as well when implementing SDM. One of these obstacles is time pressure as consultations are often quite short regarding time (Elwyn et al., 2010). Medical consultations are often between ten to twenty minutes long (Irving et al., 2017). This can make the physician feel like there is no time to discuss treatment options (Elwyn et al., 2010; Elwyn et al., 2012; Joseph-Williams et al., 2014). According to Légaré and Thompson-

Leduc (2014), this is a myth because there is very little evidence that SDM actually causes the consultations to be longer than usual. Moreover, hospitals are sometimes concerned that implementing SDM during consultations leads to more costs. However, there is no evidence that this practice is more expensive than the conservative way. It has to be taken into account that SDM might lead to less non-optimal treatment options and therefore save some unnecessary treatment costs (Légaré & Thompson-Leduc, 2014).

Insights on the topic of physicians' opinions on SDM are valuable, as the physicians' thoughts on SDM can potentially impact the actual usage of SDM. Someone that does not see the added value of SDM will probably use SDM to a lesser extent than someone who thinks that SDM is beneficial. The physicians' actual SDM usage can possibly influence the outcomes of the consultations. However, the number of recent studies that qualitatively focus on the physicians' perspective on SDM is very limited (Driever et al., 2020). Therefore, more research on the physicians' opinion on SDM is needed. This leads to the following sub research question:

Q1: What is the physicians' view on using shared decision making in consultations?

Patient demographics

A physicians' SDM usage can differ from patient to patient. The patients' demographics can play a role in this (Jolles et al., 2018). For example, research has shown that patients from ethnic minority groups often receive less SDM (DeMeester et al., 2016). Differences in communication can lead to differences in the quality of healthcare and even health inequalities. For example, people with an income below average are more likely to end up in the hospital with a disease that was preventable, because they did not get or seek appropriate care earlier. This will in turn lead to higher expenses, making medical care for poor people even harder (Stiehm, 2001). Besides poverty, some other factors have been linked to health inequalities. Health inequalities can influence the communication between a physician and a patient. This also means that the SDM usage can be influenced by patient demographics such as gender, ethnicity and socioeconomic status (Stiehm, 2001). Gender, ethnicity, and SES will be discussed in relation to SDM in further detail below.

Gender

According to Bertakis (2009), female and male patients differ in regard to how they use healthcare. For instance, female patients have more health-related appointments with physicians and use more preventive services than male patients. On the other side, physicians will have more conversations about smoking and alcohol use with male than female patients. Physicians will sometimes rely on gender biases when communicating with patients. Biases for male patients are that they do not talk about pain and avoid seeking medical care. In contrary, biases about female patients are that they are more sensitive to pain, but also more willing to talk about their symptoms (Samulowitz et al., 2018).

A qualitative study conducted focus groups with physicians to get a better insight in their opinions on gender differences in patients. Answers were ambiguous; one physician indicated that a patients’ gender does not make a difference and that it is more about character while another one said that female patients generally share more information about their health issues (Kronenberger, 2010). The physicians’ view on gender differences in patients can influence the communication of a physician towards a patient as well.

There is some knowledge about female and male patients regarding affective communication, such as physicians will use more emotional support with female than male patients (Street, 2002). However, there is not much knowledge yet about different patient genders and their influence on the physicians’ SDM usage. Based on the ambiguous answers and lack of knowledge about physicians’ SDM usage and different patient genders in consultations, the following sub research question was derived:

Q2a: To what extent do physicians believe they use and/or adapt SDM during consultations based on the patients’ gender?

Ethnicity

Patients from ethnic minorities, so people with a different culture, religion or mother tongue than most others in a group or country seem to have less access to good quality healthcare (Perloff et al., 2006). Cultural and language barriers can lead to difficulties in communication between the physician and the patient from a minority group (DeMeester et al., 2016). Besides that, patients of various ethnicities communicate in different ways about their symptoms, if the symptoms are mentioned at all (Szczepura, 2005). That means that some patients will likely not receive enough high quality care in time if the patients’ symptoms are not mentioned at all or in an ambiguous way. The physicians’ lack of knowledge about the patients’ symptoms has an influence on the patients’ life expectancy, in a way that less access or poorer quality healthcare can lead to an earlier death (Myers, 2009).

A literature review has shown that physicians rely on stereotypes when treating patients, especially when quick decision making is needed (Perloff et al., 2006). Physicians have biased expectations, although they think that they treat each patient objectively and without any biases. A bias for patients with a darker skin tone is that they are less healthy than people with a lighter skin tone (Perloff et al., 2006). A study in which physicians rated patients with a darker skin tone and patients with a lighter skin tone on different variables showed that patients with a darker skin tone were perceived as less intelligent than white patients. This result was found despite controlled factors such as education, gender and income (Van Ryn & Burke, 2000). The physicians seems to communicate differently as well to those diverse groups. Ethnic minorities seem to receive less supportive talk but also less information (Cooper & Roter, n.d.). Hence, ethnic minorities seem to receive lower quality care (Cooper et al., 2006).

Patients from an ethnic minority are at higher risk of receiving poor or no SDM than patients from an ethnic majority (DeMeester et al., 2016). A survey showed that patients from an ethnic minority would more often indicate that the physician took the treatment decision, as opposed to the patients from an ethnic majority who more often indicated that they took the treatment decision together with the physician (Ratanawongsa et al., 2010). Furthermore, ethnic minority patients get less information about the treatment possibilities than ethnic majority patients (Lin & Kressin, 2015). However, these studies show the patients' point of view on the physicians SDM usage. The physicians' view of SDM usage can be different in comparison to the patients' view and therefore the following sub research question is proposed:

Q2b: To what extent do physicians believe they use and/or adapt SDM during consultations based on the patients' ethnicity?

Socioeconomic status

Socioeconomic status (SES) is an outcome of social and economic factors of a person combined. Examples of these factors are income, level of education and profession (American Psychological Association, n.d.). Years of education is linked to future health outcomes, in a way that more years of education lead to better health outcomes (Smith, 2004). SES has an influence on health and can lead to health inequalities. One of the reasons for this is because SES is related to using health information, meaning that higher SES patients are more likely to actively search for and use health information as opposed to lower SES patients (Richardson et al., 2012). Using health information is linked to health behaviors such as physical activity, smoking and fruit and vegetable consumption (Ishikawa et al., 2012). In general, people associated with a higher SES will have a better health than people associated with a lower SES (Adler & Ostrove, 1999). Moreover, parental income is related with some childhood diseases in such a way that higher parental income is associated with less childhood diseases. This can set the tone for future health outcomes (Smith, 2004).

According to Arpey et al. (2017), physicians perceive patients with lower SES as less intelligent and responsible. Besides that, physicians think that the treatment adherence of lower SES patients is worse than that of higher SES patients. Moreover, physicians have the idea that lower SES patients have less social support in their surroundings in comparison to higher SES patients (van Ryn & Burke 2000). Physicians perceive that patients with lower SES often ask less questions during a consultation than patients with a higher SES. That makes the physicians think that patients with lower SES have less need for information and thus will the physicians provide these patients less information (Willems et al., 2005).

Regarding SDM, lower SES patients will relatively more often prefer their physician to make treatment related decisions compared to higher SES patients (Murray et al., 2007). Besides that, lower SES patients are more likely to rely on the physicians’ information without asking further questions (Yin et al., 2012). Moreover, lower SES patients will sometimes experience difficulties expressing their preferences and values regarding the treatment when participating in SDM (Castaneda-Guareras et al, 2016). This can be the reason why physicians are more likely to direct the conversation and less likely to use SDM during consultations with lower SES patients (Frantsve & Kerns, 2007). However, this information does not tell anything about the physicians’ view of using SDM with lower SES patients even though this is important for physician-patient communication. Therefore, the following sub research question is proposed:

Q2c: To what extent do physicians believe they use and/or adapt SDM during consultations based on the patients' SES?

The impact of gender, ethnicity, and SES on shared-decision making

Gender, ethnicity, and SES can all separately impact the communication from a patient to a physician and the other way around. But, interaction between those variables is possible as well, and this can also affect the communication from both the physician and the patient and ultimately the health outcomes. SES and gender can be linked to one another and seem to have an influence on a persons' weight. Research has shown that women tend to have a lower body mass index (BMI) when they have a higher SES, while men show the opposite pattern (MacIntyre & Hunt, 1997). An association is also found between SES and ethnicity. The literature showed that people with a darker skin tone often have a lower SES than people with a lighter skin tone in the United States. On top of this, the morbidity and mortality rates of people with darker skin tones are higher than those of people with lighter skin tones (Anderson et al., 1995). Moreover, patients with a darker skin tone and patients with lower SES seem to have greater chances to receive a more advanced diagnosis in comparison to their white or high SES counterparts (Gupta et al., 2022).

The physicians' attitude towards patients associated with higher SES or patients with a lighter skin tone is better than patients associated with lower SES or people with a darker skin tone. (Perloff et al., 2006). One reason for this is that lower SES patient are associated with a higher likelihood of risk behavior and worse adherence to treatment (van Ryn & Burke, 2000). A survey showed that 70% of physicians think that there are disparities due to patients from ethnic minorities with lower SES. However, only 40% of those physicians thought that these disparities occurred within their own patients (Kendrick et al., 2015).

Gender, ethnicity and SES have shown possible influences on the physicians' SDM usage. However, it remains unclear to what extent the possible interaction between these three variables influence the physicians' SDM usage. For example, ethnic minority patients that are often linked to lower SES, may receive less SDM from the physician (Castaneda-Guareras et al, 2016). In order to find out the potential impact of gender, ethnicity, and SES on SDM usage by physicians, the following research question is presented:

RQ: To what extent do gender, ethnicity, and SES influence the view of physicians on using shared decision making during their consults?

Method

Research design

A better understanding of the physicians' view on SDM was required in order to answer the research question. Therefore, interviews were held as this allows to examine the physician experiences in detail (Hennink et al., 2010). More specifically, in-depth semi-structured interviews were conducted with physicians from different specialisms. Semi-structured interviews mean that specific questions were asked within the topic, but while leaving enough room for elaboration on certain topics or additional questions (Galletta, 2013). For this study, interviews were used that were conducted in January 2022 by one researcher [KT], as well as a new round of interviews, including several additional questions, conducted in April 2023 by three researchers [KT, SV, & JB]. Both rounds of interviews were conducted based on the same interview protocol. In these interviews, physicians were asked for their opinions on their communication and SDM usage during consultations. An overview of the interview questions can be found in Appendix A and the supplementary interview questions that have been added in round two of the interviews can be found in Table 1. The second round of interviews was added to get a better understanding of physicians' SDM usage during consultations while taking the patient demographics SES, ethnicity and gender into account. This research was ethically approved by the Elisabeth-TweeSteden Ziekenhuis (ETZ) and was found to be non-WMO research by the Medical Ethical Review Committee Brabant.

Table 1

Supplementary interview questions asked during round 2 of interviews

Question	Follow-up question
Do you think that patients who differ based on gender, ethnicity or SES have a different need regarding SDM?	If yes, what makes you think that? If no, why not?
Do you adapt your SDM usage based on patient demographics such as gender, ethnicity or SES?	If yes, how do you adapt your SDM usage based on this?

Participants

In total, sixteen interviews were conducted. Thirteen physicians were working at Elisabeth-TweeSteden Ziekenhuis in Tilburg, one physician was working at HeartLife Klinieken Utrecht, one physician was working at Maasziekenhuis Pantein, and one physician was working at Spaarne Gasthuis. Different medical specialisms were included in this study, namely five cardiologists, five neurologists, three surgeons, one psychologist, one pediatrician, and one orthopedist. The age of these participants ranged from 25 to 64 years old (*M* = 40.7; *SD* = 11.82).

Procedure

To recruit participants for this study, physicians were personally asked via email to participate in this study. Next, a date was planned to schedule the interview. The physicians signed an online consent form for participation, which they needed to do before the interview itself. The form can be found in Appendix B. Two factors were taken into consideration when selecting the participants. The first requirement for the physician was having clinical consultations with patients. The second requirement was more practical: the physicians needed to be available between certain weeks. The first round of interviews was conducted between week 47 to week 50 in 2021 and the additional data was obtained between week 15 and week 18 in 2023.

As COVID-19 still played a role at the end of 2021, the first round of interviews was held online via Zoom or Teams. Due to practical reasons, the second round of interviews was online as well. All interviews were between 29 and 50 minutes long. Each interview was held by two interviewers. One was the leading interviewer, meaning that this person asked most of the questions. The other person was mainly for taking notes during the interviews. The procedure for the interviews was as follows: the interviewer would start with thanking the participant for his or her time and explain the purpose of the studies. Thereafter, the participant was asked for consent to record the audio and then the interview questions were asked. All data of the interviews was stored in Surfdrive to ensure the safety of the data. Because the physicians' as well as the researchers' native language was Dutch, the interviews were conducted in Dutch.

Data analysis

To analyze the data, a thematic analysis was used as described in Braun and Clarke (2006). After the interviews were conducted, the audio recordings were transcribed according to a codebook. An extract of the transcription can be found in Appendix C. Codes were mainly derived from the research questions and previous literature, but also from the answers in the data. The codes formed groups, the so-called subthemes. The subthemes were clustered in the main themes. This analysis was done to get an overview of all relevant answers in the data (Braun & Clarke, 2006). Both inductive and deductive coding were used. Data was analyzed with the program Atlas.ti 23.

The first theme was ‘SDM is important for the patients’ autonomy’. It has one subtheme; ‘SDM leads to better treatment adherence’. This theme was meant to get a general overview of the physicians’ attitudes towards using SDM in consultations. The second theme, ‘physicians’ biases impact the communication exchange’ analyzed whether differences in patient demographics might make a difference for physicians in their communication and SDM usage. Subthemes were ‘Gender bias impacts socio-emotional exchange’, and ‘ethnicity bias impacts socio-emotional exchange’. The last theme was ‘lower SES patients receive less SDM’ reviewed the impact of various SES patients on the physicians’ SDM usage. This theme was formed by the following subthemes; ‘recognizing lower SES patients’, ‘physicians will adapt their communication and SDM usage to lower SES patients’, and ‘consultations with lower SES patients are generally harder’. All themes, subthemes, accompanying codes and examples of each code can be found in Appendix D.

Results

Sixteen interviews were conducted in order to explore the physicians’ perspectives on their SDM usage during consultations. A thematic analysis was used as that allowed to find patterns (themes) and corresponding subthemes in the data (Braun & Clarke, 2006). In total, three themes and six subthemes were found. This was done to answer the research question ‘*To what extent do SES, ethnicity and gender influence the view of physicians on using shared decision making during their consults?’* In the first part, the physicians’ opinions on their

SDM usage and the value of SDM usage during consultations will be discussed (*Q1*). Thereafter, physicians' communication and SDM usage is discussed in regard to different patient demographics, namely gender (*Q2a*), ethnicity (*Q2b*) and SES (*Q2c*).

SDM usage during consultations

The first theme, 'SDM is important for the patients' autonomy' identified how physicians think about using SDM during consultations by means of one subtheme (*Q1)*. The subtheme discovered that SDM would lead to better treatment adherence. Ten physicians were asked in what place they would rank SDM out of the three communication elements. The physicians rated SDM as the second most important element in consultations, just after giving medical information (n = 5). The physicians of all different specialisms (N = 16) agreed on the importance of SDM usage during consultations as they did indicate that SDM plays an important role. Moreover, three physicians mentioned that a patient should be able to decide about his or her own body (n = 3). According to some physicians (n = 2), using SDM is a way of showing respect to the patient. Besides that, physicians indicated that a treatment that was chosen via SDM had a higher chance of being supported by the patient than a treatment that was chosen by the physician only. That is why physicians believe SDM could help with better treatment adherence and should therefore be desired (n = 4). This is supported by the following quotation: "I think if it feels like their [a patients'] own decision, they will better follow up on it" (A2).

Physicians also indicated that SDM sometimes went too far (n = 3) because they would give the patients options that were not options at all, as in the following quote: "people have their right of self-determination and decide, of course, themselves what will happen, but sometimes you [physician] will go completely overboard. So we [physicians] will give the patients choices, that are not even choices at all." (A13)

The physicians explained that they would describe the treatment options, for each including the risks, advantages and disadvantages (*n* = 6). A treatment decision was taken together, but the physician would indicate what their preference would be regarding the treatment (*n* = 7). One physician made clear that physicians try to give the patients the feeling of SDM, nonetheless they will likely influence the patient to make a certain choice (*n* = 1).

Besides that, SDM is not as suitable for every situation. One physician indicated that an emergency situation is less suitable for SDM (*n* = 1), because the decisions need to be made quickly. This is demonstrated in the quotation below:

> “You often can’t oversee everything in such a quick emergency situation, there is of course anxiety and emotion, so it [SDM] will be less extensive, I think I will take the decision more often eventually. But I will always discuss it with them [patients] and their family” (A14).

Moreover, physicians noted that SDM was not as successful for every patient (*n* = 7). Mainly elderly patients would prefer the physician to take treatment related decisions (*n* = 4). One physician noted that patients can get insecure from hearing all treatment options, as illustrated in the following quotation: “there are many patients that will feel very insecure if they hear me explain all treatment options. If I notice that they get insecure, I will take over” (A4).

Physicians’ communication and SDM usage for patient with various demographics

The second theme, ‘physicians’ biases impact communication exchange’ was formed by two subthemes and reviewed the impact of various patient demographics in relation to the physicians’ communication and SDM usage. The first subtheme identified that gender biases can impact the physicians’ communication (*Q2a*). The answers that the physicians gave during the interviews showed that physicians feel as if female patients tend to go to the physician sooner than male patients (*n* = 4). Furthermore, some physicians mentioned that female patients would describe their aches in more detail than male patients (*n* = 5). This is illustrated in the following quotation: “So if a female experiences something [pain], she will go to the physician sooner than a male. And often when the male is the patient, a female pushed him to go to the physician.” (A6). Two physicians indicated that females are emotionally more intelligent and will therefore show more emotions during consultations (*n* = 2). However, physicians also pointed out that male and female patients do have the same need for emotional support but males will not let it show as quickly as females do (*n* = 5).

Regarding SDM usage, six physicians were asked the additional question in the second round of interviews whether they thought they used SDM in a different way for male and female patients. Four physicians revealed that they did not notice any differences in SDM preferences from male and female patients (*n* = 4). This also meant that the physicians would not consciously adapt their SDM usage based on the patients’ gender (*n* = 4). The following quotation clarifies this:

> “well I don’t think gender is that much of a factor, I don't take that into account at least on the front end. In practice, I also notice that they [male and female patients] have the same need when you talk about the Dutch population.” (A16).

The second subtheme showed that ethnicity biases can impact the communication from a physician (*Q2b*). Opinions on the topic of communication with non-Dutch patients during consultations were divided. Some physicians indicated that they tried to not adapt their communication to patients with a non-Dutch ethnicity, unless there was a language barrier (*n* = 7). Others said that they would adapt their communication because of cultural differences between Dutch and other cultures (*n* = 9). It was noted that in the Dutch culture, people often speak in a direct way, whereas other cultures are often more careful with their words (*n* = 3), as in the following illustration: “I will approach them [non-Dutch patients] in a less direct way and explain the prognosis more cumbersome” (A1). Multiple physicians also indicated that people from some cultures expect a certain treatment (*n* = 4), such as antibiotics (*n* = 1) or a MRI (*n* = 2) while that treatment is unusual for the disease in Dutch culture. This is illustrated in the following quotation:

> “[…] and then there is a standard example of Turkish ladies who don't want surgery but want a solution to their knee pain and they want an injection. And then you can tell a whole story, but they're not waiting for that.” (A16)

According to physicians, the main issue with patients from non-Dutch ethnicity is a language barrier (*n* = 8), as it would take more time to explain the symptoms and the treatment. A translator was sometimes needed (*n* = 7). This is supported by the following quotation: “and if they [non-Dutch patients] don’t speak the language [Dutch] is it really a hell of a job to communicate clearly with them.” (A12).

One physician noted that ethnicity can sometimes be linked to gender. In some cultures is it unusual that a woman decides, so her husband or partner will take the decisions for her (*n* = 1).

The physicians’ answers from the interviews showed that not every culture is as used to SDM as how it is used in Dutch hospitals. Physicians indicated that patients from non-Dutch ethnicities would sometimes say things like ‘you are the physician so you should decide’ (*n* = 4). Physicians said that non-Dutch patients might even think that the physician was not knowledgeable about the symptoms (*n* = 3). The differences regarding SDM preferences are illustrated in the quotation below:

> “[…] I [physician] often leave that shared decision out with some ethnicities. Whereas if you get an American, for example, you have to do shared decision making because he has actually already made a list of what he wants.” (A2)

Furthermore, physicians noted that they would often be more directive while talking to patient from other ethnicities, meaning that the physicians would use less SDM (*n* = 9). The answers from the physicians showed that there were two reasons for this, first one: patients from cultures such as Turkey, Morocco and Poland expect the physician to take the decision so the patients do not want to engage in the decision making process (*n* = 5). Second, due to the language barriers that often occur, it would take too much time to discuss every option (*n* = 3) as illustrated in the following quotation: “when someone has, for example, a different ethnicity and doesn’t speak the Dutch language very well, you will discuss things [treatment options] easier and quicker because it will cost a lot of time otherwise.” (A13)

Physicians’ communication and SDM usage for various SES patients

The third theme, ‘lower SES patients receive less SDM’, was formed by three subthemes and explored the physicians’ view on SDM usage for patients with various SES *(Q2c).* The first subtheme showed the possibility to recognize lower SES patients. Most physicians indicated that it is possible to recognize patients with a lower SES (*n* = 12). Signals that revealed a possible lower SES were, among others, clothing (*n* = 3) but smell as well (*n* = 2). Moreover, language usage, intelligence and social context were other factors that could indicate a lower SES (*n* = 8). However, physicians also indicated that recognizing a lower SES was often based on prejudices and therefore not really reliable (*n* = 3). Some patients were also very good at hiding their lower SES (*n* = 7), as illustrated in the following quotation: “to be fair I think that you can’t always notice it, people are very good in hiding their problems and language delay”. (A15)

One physician indicated that migrant workers and north-African people often have a lower SES as well (*n* = 1), as illustrated in the following quotation:

> “I think that has to do with SES. If a patient comes from an average Turkish or north African family, I think mainly Turkish families will come with five or six people to the consultation. They will expect me to take a decision instead of discussing whether their grandmother should get surgery” (A10)

The second subtheme revealed if and how a physician would adapt their communication and SDM usage to lower SES patients. Almost all physicians pointed out that they adapt their communication if a patient has a lower SES (*n* = 12). Physicians mentioned that they will use easier language or repeat themselves more often (*n* = 8). Besides that, physicians will sometimes present the medical information in a visual way for the lower SES patients to make sure that the patients understand the important information (*n* = 3). This can be done through drawings, leaflets, or plastic models of an organ (*n* = 4). The following quotation illustrates this: “sometimes you use of drawings instead of leaflets. Or imagery about sewer pipes, that works quite well with blood vessels. So yes, the communication [with lower SES patients] does differ.” (A2)

Physicians noted that lower SES patients tend to value SDM less than higher SES patients (*n* = 8). According to physicians, patients with lower SES would sometimes not understand the medical information to make decisions about the treatment (*n* = 6). But some physicians also said that in comparison to higher SES patients, lower SES patients were more often convinced that the physician should make treatment related decisions (*n* = 5), as shown in the following quotation: “there are people with a low SES that go to the physician and want to hear from the physician what’s wrong and what they should do about it and that’s it.” (A1)

The third subtheme explored the physicians’ view on communication in consultations with higher versus lower SES patients. Some physicians indicated that a consultation with a lower SES patient was easier than with a higher SES patient, because the lower SES patient would not demand as much information as the patient with higher SES (*n* = 3). On the other hand, other physicians indicated that consultations with lower SES patients were harder than consultations with higher SES patients. This was because the physician had to repeat himself more often (*n* = 5). Besides that, one physician argued that lower SES patients would get angry or aggressive more easily (*n* = 1), as in the following quotation: “they [low SES patients] will quickly feel threatened. Then they will get angry, talk very loud, swear, walk away, slam doors, these kind of things. Those are the people with low SES.” (A5)

Discussion

This qualitative study aimed to examine the physicians’ view on the impact of the patients’ gender, ethnicity, and SES on using SDM during consultations via in-depth interviews. This is important because a better understanding of this topic can make physicians more aware of their way of communication and adapt it if needed. This could ultimately lead to improved communication between physicians and patients. Moreover, results from this study contribute to the existing literature about physicians’ SDM usage during consultations.

To begin with, the physicians’ opinions on SDM usage during consultations was explored (*Q1*). The first theme showed that physicians think that SDM is important for the patients’ autonomy. The subtheme identified that using SDM will lead to better treatment adherence. Results showed that physicians value using SDM in their consultations. This is in line with the findings of Pollard et al. (2015), showing that physicians are mostly positive about SDM. In this study, physicians gave multiple arguments to use SDM during consultations, such as showing respect to the patient and giving the patient the possibility to decide about their own body. Moreover, physicians said that a treatment chosen by the patient could lead to better treatment adherence. That matches the results of Dunbar-Jacob and Mortimer-Stephens (2001), as they showed that SDM is positively linked to treatment adherence. Physicians in this study indicated that they would explain the advantages, disadvantages and risks of each option with the patient. That connects to results from Stacey (2017), showing that patients will have a better perception of the treatment risks due to the explanation of the benefits and risks.

Moreover, the physicians in this study pointed out that patients would be able to choose a treatment with SDM that suites their preferences. This matches the findings of Stiggelbout et al. (2012), who showed that a benefit of using SDM is that patients will be able to choose a treatment option aligned with their preferences and values. A treatment decision supported by the patient could lead to less unnecessary harm from the other treatment options.

Physicians indicated in the interviews that they would explain the disadvantages and advantages of each treatment option, but clearly indicate their preference for a certain treatment as well. Furthermore, they pointed out that they were less likely to use SDM in case the physician thought that SDM would take too much time. The physicians indicated that they felt like they had to repeat themselves more often with lower SES patients or when language barriers played a role. This is in line with findings from Elwyn et al. (2010), stating that time pressure is an obstacle for the physicians to use SDM during consultations.

The second theme revealed that physicians will consciously adapt their communication and SDM usage based on various patient demographics, namely gender and ethnicity *(Q2A & Q2B).* The first subtheme demonstrated that physicians' biases about the patients' gender can impact the socio-emotional exchange. Physicians' answers from the interviews showed that they felt like female patients would go to a physician sooner than male patients. This is in accordance with results of Bertakis (2009), showing that female patients have more health-related appointments. The physicians in this study said that female patients talk in further detail about their symptoms than male patients. Samulowitz et al. (2018) showed that a bias for female patients is that they are more willing to talk about their symptoms than male patients, so these two results complement each other as the physicians in this study confirmed the bias about male and female patients. However, the physicians in this study indicated that despite the difference in communication between male and female patients, both genders have the same need for emotional support.

Physicians in this study felt like there were no differences regarding their SDM usage for male and female patients. This means that the physicians would not consciously adapt their communication based on the patients' gender. The literature has shown that physicians have the idea that female patients talk more and in further detail about their symptoms than male patients (Samulowitz et al., 2018), meaning that it would possibly be easier or more logical for physicians to use more SDM with female patients as well. However, physicians mentioned that try to treat each patient objectively so the amount the patient talks does probably not matter for SDM usage.

The second subtheme identified that physicians' biases about the patients' ethnicity will impact the physicians' communication. Physicians indicated to not adapt their communication to patients with a non-Dutch ethnicity, unless there were large cultural differences. Moreover, the physicians in this study pointed out in the interviews that they would adapt their communication if there were language barriers. These two reasons for physicians to adapt their communication based on the patients' ethnicity became clear in the study of DeMeester et al. (2016) as well, showing that cultural and language barriers could lead to difficulties in communication between a physician and patient. Physicians in this study stated that patients from various ethnicities all have the same need for medical information. Despite all patients having the same need for medical information, Cooper and Roter (n.d.)

showed that patients from ethnic minorities receive less medical information and less supportive talk. Perloff et al. (2006), showed that physicians often rely on biases and stereotypes. So, although the physicians in this study said that they treat each patient, when possible, in the same way, they can still unconsciously rely on stereotypes and therefore adapt their communication to a larger extent than what they are aware of. For instance, physicians can use less SDM because they see that a patient has another skin tone than the ethnic majority of a country.

Physicians in this study mentioned that non-Dutch cultures are sometimes not as familiar with SDM as in the Netherlands. According to the physicians, patients from a non-Dutch ethnicity were generally more likely to let the physician decide about the treatment, because that was the patients’ preference. This is partly in line with findings from Ratanawongsa et al. (2010), stating that ethnic minority patients feel like the physician would make the treatment decisions for them but it is not clear whether that was due to the patients’ preferences or the physicians’ communication.

The third theme showed that lower SES patients will receive less SDM than higher SES patients (*Q2c*). The first subtheme showed that it is possible to recognize lower SES patients. Physicians explained that it is possible to recognize patients with a lower SES based on the patients’ language usage, intelligence or information about their social context. However, the physicians also said that recognizing lower SES patients is often based on prejudices and therefore not always correct. That is similar to findings of Aprey et al. (2017), explaining that physicians judge patients based on biases.

The second subtheme revealed that physicians will adapt their communication and SDM usage to lower SES patients. Physicians in this study made clear that they thought patients with a lower SES would more often prefer the physician to make treatment related decisions. Physicians explained this preference by the fact that lower SES patients would sometimes not understand the medical information to make treatment related decisions and that these patients would therefore prefer the physician to make a treatment related decision. Frantsve and Kerns (2007) showed that physicians will be more directive during consultations with lower SES patients, which might be because physicians think that lower SES patients will not be able to understand the medical information. The findings of this study imply that physicians would adapt their SDM usage to the SES of a patient, in a way that physicians would use less SDM for lower SES patients.

The third subtheme demonstrated that consultations with lower SES patients are generally seen as harder than consultations with higher SES patients. Higher SES patients would ask more questions whereas lower SES patients would sometimes not understand the medical information. Moreover, physicians in this study indicated that higher SES patients more often prefer SDM than lower SES patients. These findings match the findings of Murray et al. (2007), showing that lower SES patients more often prefer their physician to make the treatment related decisions.

Theoretical and societal implications

The results of this study led to new theoretical insights on the topic of SDM usage of physicians during consultations. Physicians were asked whether they thought they adapted their communication and SDM usage based on a few patient demographics, namely gender, ethnicity, and SES. Moreover, physicians were asked about their reasoning to do so. Physicians indicated to consciously adapt their SDM usage if a patient had a lower SES or a non-Dutch ethnicity. Gender was, according to physicians, not a factor to consciously adapt SDM usage. However, it is still possible that physicians adapt their SDM usage unconsciously based on the patients’ gender, as the physicians also indicated that the communication of male and female patients differ. The impact of patient demographics on the physicians’ SDM usage during consultations is, to our best knowledge, not been studied yet with a qualitative focus on the physicians' perspective.

This study has shown how physicians think about their own communication and SDM usage. This led to an important societal implication for the healthcare field, as they probably want to ensure the highest quality care as possible. That is only possible if the communication between the physician and the patient, or the so-called main ingredient in medical care (Ong et al., 1995), is adequate. That makes it important to know how physicians view their own way of communicating to see whether it is in line with the expectations from the healthcare setting. This study has shown that physicians think that they will sometimes adapt their SDM usage based on patients' demographics. The healthcare setting can chose to adapt their policy around SDM usage based on these results.

Limitations

Some points of this study can be improved if the study is replicated in the future. First, this study was a qualitative research, meaning that the physicians gave their opinions and perspectives via in-depth interviews which is not as objective as other types of research. Despite the fact that these results are valuable and relevant, someone's opinion or perspective can differ from their actual behavior. It is valuable to enhance the generalizability of this study's results by conducting an observational study. Researchers could observe multiple consultations from the physicians that participated in this interview study in order to draw conclusions about the physicians' actual SDM usage. Results will show whether the physicians' actual behavior regarding SDM usage aligns with how they think they use SDM during consultations.

Second, physicians of a wide variety of specialisms participated in this study. This led to many different points of view, which is interesting and shows a broad view but it makes it harder to generalize the answers from the physicians as well. Physicians' opinions on SDM usage can vary per specialism or per department, for example SDM for a neurological disorder can be different from SDM usage for a broken arm. A future research recommendation would be to focus on one type of specialism if the scientific or healthcare field requires more in-depth knowledge about SDM usage from a specific department. The SDM usage policy can be adapted based on these results.

Third, all physicians were recruited via snowball sampling and were all working in the Netherlands. These results tell something about the SDM usage by physicians in the Netherlands, but to a lesser extent for other countries. The Dutch way of communicating is quite direct, and Dutch patients generally value their autonomy and thus the ability to make decisions about their own treatment (Kuijpers et al., 2021). But this can of course be different for other cultures with other norms and values. Future research could look at different countries as the policy or culture around SDM can vary per country.

Conclusion

The goal of this study was to find out the answer to the following research question: *To what extent do gender, ethnicity, and SES influence the view of physicians on using shared decision making during their consults?* In conclusion, physicians of various specialisms see SDM as very important and say that they will use it whenever possible. However, physicians will not use SDM in the same way for each patient. A reason for this can be found in different patient demographics. Physicians mentioned that they would adapt their communication and therefore SDM usage based on the patients' SES, as patients with a lower SES are more likely to let the physician decide about the treatment. Furthermore, physicians indicated that a patients' ethnicity could lead to differences in the physicians' communication and therefore SDM usage as well. The physicians argued that there were often language or other barriers, such as patients' preferences, with patients from a non-Dutch ethnicity. Physicians indicated that gender, so female or male patients, did not make a difference regarding SDM usage. Findings from this study have contributed to the scientific and healthcare field by showing insight in the physicians’ view regarding SDM usage from patients from varying demographics.

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Appendices

Appendix A: Interviews Artsen: Richtlijn voor de interviews

Opening:

Alvast ontzettend bedankt dat u deel wilt nemen aan dit onderzoek. Ik stel voor dat we direct beginnen gezien de tijd. Zoals aangegeven zijn wij erg benieuwd naar de mening en ervaringen van artsen over de communicatie met hun patiënten en dan met name laag sociaal economische status patiënten. Laag sociaaleconomische status patiënten zijn patiënten die onder andere een lager opleidingsniveau hebben, lager inkomen, en ongeschoold of laaggeschoold werk verrichten. Het interview zal ongeveer 30 minuten duren en is als volgt opgebouwd: we beginnen met wat algemene vragen over uw ervaring met de communicatie met ***alle*** *patiënten. Vervolgens heb ik wat specifieke vragen over lage-SES patiënten. We sluiten af met enkele vragen van mijn scriptiestudenten die ook een erg interessant onderzoek doen.*

Thema 1: Ervaringen met de communicatie

De volgende vragen zullen gaan over de gesprekken tussen u en uw patiënten tijdens het spreekuur. Er zijn geen goede of foute antwoorden, we zijn simpelweg benieuwd naar hoe artsen de interacties met patiënten ervaren.

1. Allereerst zou ik graag het volgende willen weten; kunt u vertellen hoe een consult bij u er ongeveer uit ziet?
    a. Doorvraag: Hoe zou u uw manier van communiceren met de patiënt(en) kort omschrijven?
2. Welke onderdelen van het consult met uw patiënten hecht u extra veel waarde aan?/ Wat vindt u echt belangrijk in het consult?
3. Hoe belangrijk vindt u de interactie tussen u en uw patiënten?
    a. Doorvraag: Als u kijkt naar een, in uw ogen, succesvol consult, hoeveel procent wordt daarvan bepaald door goede interactie?
4. In hoeverre merkt u verschillen tussen patiënten en hun communicatievaardigheden? Past u uw communicatie aan de communicatie van de patiënt?

Thema 2: Behoeften communicatie

Dan zou ik nu graag wat dieper ingaan op verschillende onderdelen van het gesprek. Het delen van medische informatie is natuurlijk een groot onderdeel van het gesprek tussen arts en patiënt. Deze medische informatie is voor u natuurlijk vanzelfsprekend maar

5. In hoeverre is het in uw ogen belangrijk om zo correct en volledig mogelijk alle medische informatie te delen met uw patiënten?
    a. Doorvraag: Kan dit verschillen van patiënt tot patiënt?

Een ander kenmerk van dokter-patiënt gesprekken is dat dit soms verschillende emoties kan opwekken bij de patiënt en dat de patiënt soms behoefte heeft aan empathie en/of emotionele support.

6. Merkt u dat goed dat patiënten soms behoeften hebben aan emotionele support?
    a. Doorvraag: Laten de patiënten dit duidelijk merken?
7. Vindt u het zelf ook belangrijk dat emotionele steun en empathisch begrip onderdeel is van het gesprek?
    a. Doorvraag: op welke manier probeert u emotionele steun te laten zien?/onderdeel te laten zijn van het gesprek?

Verder is waarschijnlijk bekend dat gedeelde besluitvorming, ofwel shared-decision making, ook een steeds belangrijker onderdeel wordt van het gesprek.

8. In hoeverre speelt gedeelde besluitvorming in uw gesprekken ook een rol? *Dit kan namelijk verschillen per specialisatie*
    a. Doorvraag: en hoe belangrijk vindt u gedeeltelijke besluitvorming?
9. In hoeverre vindt u het belangrijk dat de patiënt meedenkt bij het maken van een besluit?
    a. Doorvraag: Verschilt dit van patiënt tot patiënt?

Deze vorige drie onderwerpen; het geven van medische informatie, emotionele steun, en gedeelde besluitvorming komen in de literatuur vaak voor als een driedeling te vinden in het gesprek tussen artsen en patiënten. We hebben het er net natuurlijk al even over gehad maar

10. Als u deze drie nou zou moeten ranken, welke vindt u dan het belangrijkst in een gesprek? / welke zou u dan bovenaan zetten?
    a. Doorvraag: Kunt u dit verder toelichten?
11. Nu is dit natuurlijk wat u zelf het belangrijkst vindt maar merkt u zelf ook verschil tussen verschillende patiënten en waar zij behoefte aan hebben?

Dank u wel voor uw antwoorden tot dusver, ik heb nog enkele specifiekere vragen voor u. In deze studie hebben wij, zoals eerder aangegeven, extra aandacht voor het gesprek tussen artsen en lage sociaaleconomische status patiënten.

12. Allereerst, heeft u zelf door/denkt u dat het mogelijk is om door te hebben wanneer uw/een patiënt een lagere sociaaleconomische status heeft?
   a. Doorvraag indien ja: hoe merkt u dit?
   b. Doorvraag indien nee: En hoe komt dat denkt u?

13. Wat is uw ervaring met de interactie met laag sociaaleconomische status patiënten specifiek?
   a. Doorvraag: En op welke gebieden merkt u verschil met hoger opgeleide patiënten?

14. Ervaart u bepaalde struikelblokken/hindernissen tijdens het communiceren met laag sociaaleconomische status patiënten?
   a. Doorvraag indien ja: welke zijn dit?
   b. Doorvraag indien nee: Hoezo niet denkt u?

Nog even terugkomend op de drie onderdelen van het gesprek (informatie, affectief, en gedeelde besluitvorming) en laag sociaaleconomische status patiënten specifiek:

15. Denkt u dat/merkt u dat laag sociaaleconomische status patiënten andere behoeften hebben in vergelijking met hogere sociaaleconomische status patiënten met betrekking tot deze drie factoren van het gesprek?
   a. (Eventueel uitweiden: denkt u dat lage-SES patiënten meer waarde hechten aan een van de drie onderdelen van het gesprek en dat dit misschien anders is dan patiënten met een hogere SES?)

Nu ben ik vooral zelf aan het woord geweest met wat voor mij bekend is uit de literatuur over het gesprek tussen arts en laag sociaaleconomische status patiënt

16. Maar zijn er bepaalde zaken waar u zelf tegenaan loopt tijdens consulten met lager sociaaleconomische status patiënten wat ik nog niet heb besproken?

Bedankt voor uw antwoorden tot dusver, ik heb nu nog enkele extra vragen van mijn scriptiestudenten, zij doen allebei een erg interessant onderzoek. Een van de onderzoeken gaat over shared-decision making, de ander over levensstijl adviezen.

De volgende vragen gaan specifiek over shared-decision making. Uit de literatuur is gebleken dat artsen niet bij elke patiënt dezelfde mate van shared decision making gebruiken. Dat wordt mede bepaald door het geslacht, etniciteit en sociaaleconomische status van de patiënt. Allereerst ben ik benieuwd of u...

17. Heeft u het idee dat patiënten die verschillen op het gebied van geslacht, sociaaleconomische status, of etniciteit gezien, andere shared-decision making behoeften hebben?

18. en past u ook uw eigen niveau van shared-decision making aan op basis van patiënt kenmerken als geslacht, sociaaleconomische status of etniciteit?
   a. Zo ja, wat doet u daartoe besluiten?
   b. Zo nee, waarom niet?

De volgende vraag gaat over communicatie en de levensstijl van de patiënt. Denk aan aangeven dat roken slecht is. Uit onderzoek blijkt namelijk dat de levensstijl die mensen hebben invloed kan hebben op hun gezondheid en het verbeteren van de gezondheid. Allereerst ben ik benieuwd of u …

19. Communiceert u naar de patiënt dat levensstijl belangrijk is en blijft?
   a. Doorvraag indien ja: op welke manier communiceert u dit?
   b. Doorvraag indien nee: waarom niet?

20. In hoeverre denkt u dat uw communicatie over gezonde levensstijl adviezen wordt beïnvloed door de sociaaleconomische status van de patiënt?

21. In hoeverre denkt u dat het geven van adviezen over de levensstijl effectief is?
   a. Doorvraag: denkt u dat hier ook nog verschil in zit als het gaat om hoge SES of lage SES patienten?

Appendix B: Online consent form

Tilburg University

Dank u wel voor uw interesse in deze interviewstudie. We zijn benieuwd naar de mening en ervaringen van artsen met de communicatie en dan met name de communicatie met laag sociaal economische status patiënten. Hieronder vindt u het consentformulier. Als u toestemming geeft voor het onderzoek vindt u op de volgende pagina nog enkele demografische vragen.

Als u mee wilt doen aan dit onderzoek kunt u hieronder toestemming geven. Uw deelname aan dit onderzoek is geheel vrijwillig. Tijdens het onderzoek heeft u het recht om u te allen tijde terug te trekken, om welke reden dan ook en zonder dat dit nadelige gevolgen heeft.

Als u deelname accepteert, geeft u aan dat u:

- Ouder bent dan 18 jaar;
- Alle informatie heeft gelezen;
- Ermee instemt dat de geanonimiseerde data tien jaar opgeslagen zullen worden;
- Ermee instemt dat de gegevens gebruikt kunnen worden voor verder wetenschappelijk onderzoek of wetenschappelijke publicaties;
- Ermee instemt dat anonieme gegevens gedeeld kunnen worden met andere onderzoekers;
- Begrijpt dat u zich te allen tijde en zonder opgeven van een reden terug mag trekken

Ik geef toestemming voor deelname en begin met het onderzoek

Ik geef geen toestemming en wil niet meedoen met het onderzoek

Indien u toestemming heeft gegeven voor deelname, plaats hier uw handtekening:

Appendix C: Transcript extract

Interview 17 03-05-2023

Duur: 33.09 [00.00 – 31.13]

Interviewer 1: Sophie (S)

Interviewer 2: Julia (J)

Arts A17

Geslacht: man

Leeftijd: 25

Afdeling: chirurgie

Ziekenhuis: Spaarne Gasthuis

S: nouja dan ga ik maar meteen beginnen met het interview. De volgende vragen zullen gaan over de communicatie tussen u en uw patiënten tijdens het spreekuur. Er zijn dus geen goede of slechte antwoorden. Eh dus allereerst zou ik graag willen weten in welk specialisme bent u werkzaam en hoe een consult er bij u ongeveer uitziet.

A17: ehm nou zeg maar je, ik ben 25. Ik zit nu bij chirurgie, daar doe ik een arts stage. Ehm en je hebt bij ons een beetje een verschil tussen waar je staat, dus je hebt de afdeling, de polikliniek en de spoedeisende hulp. En ik denk dat de polikliniek en de spoed het meeste lijken op een consult. Polikliniek dan haal je iemand uit de wachtkamer, vaak hebben ze een nieuw probleem, de huisarts heeft ze doorgestuurd en dan vraag je dat gewoon uit. Ehh en dan doe je een beetje de onderzoekjes die bij jou specialisme passen. En spoedeisende hulp krijg je vaak helemaal niks te weten, dan staat er bijvoorbeeld val op hoofd. En dan begin je gewoon van voor, van vooraf aan en kan je eigenlijk alle onderzoeken aanvragen waarvan je denkt dat het nuttig is. Dus dat een beetje.

S: oke, en hoe zou je dan ook je manier van communiceren met de patiënt kort omschrijven?

A17: ehm ja altijd wel op een nette manier, dus je begint altijd met u, je stelt jezelf even voor, dus wat je naam is en wat je functie is en ik begin vaak met ik heb al een beetje wat gelezen mar kunt u zelf vertellen waarom u hier bent?

S: oke en welk onderdeel van het consult hecht je dan extra veel waarde aan dus wat vind je extra belangrijk tijdens een consult?

A17: de anamnese is natuurlijk heel belangrijk want daar kan je natuurlijk vrijwel alle informatie uit krijgen. Ja en daarna heb je natuurlijk lichamelijke onderzoeken waarmee je de anamnese kunt aanvullen maar zonder goede anamnese kom je nergens.

S: nee precies. En in hoeverre merk je verschillen bij patiënten in hun communicatievaardigheden dus pas je dan ook je communicatie aan aan de communicatie van de patiënt?

A17: eh ja je moet natuurlijk ook een beetje bedenken wat het niveau is van de patiënt, alsin taalgebruik. Ehm en dat merk je vanzelf wel een beetje. Eh en ja kijk je moet sowieso een beetje oppassen met medische termen want dat begrijpen mensen vaak niet zo goed. En ja als mensen wat minder intelligent zijn, ja dan kan je moeilijke woorden gebruiken maar dan snappen mensen aan het einde van het uur nog steeds niet wat je hebt gezegd. Dus op die manier pas je het een beetje aan.

Appendix D: All themes and codes used to analyze the interviews

Themes	Subthemes	Codes	Examples
SDM is important for patients' autonomy	SDM leads to better treatment adherence	SDM lets the patient decide about their own body	"The body is from the patient and they can choose themselves what they want"
		Treatment adherence	"The patient needs to be intrinsically motivated to adhere to treatment which is why you take the treatment decision together"
		SDM shows respect to the patient	"The body is from the patient and they can choose themselves what they want"
		Patients' perceived control	"If it feels like a patients' own decision, they will follow up better on it"
		High preference for control	"I have a few patients that endlessly want to discuss the treatment options, so they will have a larger need for SDM"

physicians’ biases impact communication exchange	Gender bias impacts socio-emotional exchange	Communication female patients	“Female patients can talk endlessly about why they have those complaints”
		Communication male patients	“Male patients are much clearer in explaining their complaints”
		Emotional support	“So I think female and male patients have the same need for emotional support if we forget about our own normative beliefs”
		Gender and SDM	“I notice that Dutch female and male patients have the same needs regarding SDM”
	Ethnicity bias impacts socio-emotional exchange	Expectations from the treatment	“Polish males will come in and say that they want a MRI”
		Cultural differences	“Some cultures will wait way longer before they go to the physician with certain complaints”
		Language barriers	“You have to explain everything via a translator. And than they will go home with empty hands”

		Non-Dutch ethnicities and SDM	“The physician doesn’t know, he is asking me what it is, that is weird”
Lower SES patients receive less SDM	Recognizing lower SES patients	Lower SES biases	“If someone comes in badly cared for with uncut nails or yellow ends and smelling like cigarettes you know enough”
		Recognizing lower SES based on verbal behavior	“you can recognize lower SES patients base don their way of talking”
	Physicians will adapt their communication and SDM usage to lower SES patients	Easier language	“It does matter how you explain the medical information. So that can be in a childish way, or with a lot of examples”
		Visual information	“I have special PowerPoints, plastic hearts and veins et cetera. I can explain everything in a visual way”
		Understanding medical information	“I’ll sometimes stop explaining the medical information because it is too much. The rest will come the next time”

		Low preference for control	“Lower SES patients will more often say just tell me what to do and I’ll follow up on that”
	Consultations with lower SES patients are generally harder	Repetition	“You need more repetition to get the medical information across”