



**TOO COMPLEX AND TIME-CONSUMING TO FIT IN!
Physicians' experiences of elderly patients and their
participation in medical decision making: a grounded theory
study**

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TOO COMPLEX AND TIME-CONSUMING TO FIT IN!

Physicians' experiences of elderly patients and their participation in medical decision making: a grounded theory study

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Abstract

Objective

The objective of this study is to explore physicians' thoughts and considerations of participation in medical decision making by hospitalised elderly patients.

Design

A qualitative study using focus group interviews with physicians interpreted with grounded theory and completed with a questionnaire.

Setting and participants

The setting was three different hospitals in two counties in Sweden. Five focus groups were conducted with physicians ($n = 30$) in medical departments, with experience of care of elderly patients.

Results

Physicians expressed frustration at not being able to give good care to elderly patients with multimorbidity, including letting them participate in medical decision making. Two main categories were found: 'being challenged' by this patient group and 'being a small part of the health care production machine'. Both categories were explained by the core category 'lacking in time'. The reasons for the feeling of being challenged were explained by the subcategories 'having a feeling of incompetence', 'having to take relatives into consideration' and 'having to take cognitive decline into account'. The reasons for the feeling of 'being a small part of the health care production machine' were explained by the subcategories 'At the mercy of routines'

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3 and 'inadequate remuneration system' both that do not favour elderly patients with
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6 multimorbidity.
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8 **Conclusions**

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10 Physicians find that elderly patients with multimorbidity give rise to frustration by giving them a
11
12 feeling of professional inadequacy, as they are unable to prioritise this common and rapidly
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14 growing patient group and make them participate in medical decision making. The reason for
15
16 this feeling is explained by lack of time, competence, holistic view, appropriate routines, and
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18 proper remuneration systems for treating these patients.
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23 **Article summary**

24 **Article focus:**

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- Physicians views and attitudes to elderly patients participation in medical decision making

Key messages:

- That hospital care is not well adapted to the elderly with multimorbidity which are a highly complex patient group to take care of.
- Taking care of elderly patients with multimorbidity often frustrates physicians by giving them a feeling of professional inadequacy
- The remuneration systems do not allow for necessary time for communication between medical professionals and between physicians and patients/relatives. Neither do they support the necessary integration of care.

Strengths and limitations:

Strengths:

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- The scope of the study which to the authors knowledge has not been clearly documented in earlier studies and is important to bear in mind when planning for future health care, especially as there will be a growing proportion of frail elderly people.

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Limitations:

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- Qualitative research limits generalization
 - The study was performed in a Swedish context

Introduction

Health care professionals have a responsibility to involve patients in medical decision making.

This has been accepted as ethically appropriate practice for decades and is a part of health care legislation in many countries.¹⁻⁵ The literature on the advantages of patient participation is abundant with better treatment results and higher patient satisfaction.⁶⁻¹²

Studies in the area of medical decision making show that most patients prefer shared decision making, but that preferences are very individual.¹³ Several factors have influence, such as age, sex, and level of education, but the relationship is not constant.¹⁴⁻¹⁷ Several studies have focused on older patients with cancer and chronic diseases.^{14-16 18 19} Most have found a decline in the wish for involvement, as patients get older.^{17 20-24} One of the reasons reported for not participating was the patient feeling subordinate to the hospital as an institution of power.²⁵

In contrast to the multitude of publications on patient participation, there is a lack of studies of physicians' preferences and behavior related to stimulating patients to partake in decision making.²⁶ Some studies have shown that attitudes towards involving patients range from highly positive to more circumspect, and that moves towards enhancing patient involvement in decision making will depend on developing both the skills and attitudes of medical professionals.^{21 27} Further influence is exerted by the conflict of demands on resources within the collectively funded health care system²⁸ and lack of time.²⁹

In summary, we know much about the benefits of patient participation in medical decision making and some about the elderly and their preferences related to this process. However, very little is known about physicians' thoughts and considerations regarding patient participation, particularly among elderly patients. The aim of this study is to explore physicians' thoughts and

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3 considerations of participation in medical decision making by hospitalised elderly patients with
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6 multimorbidity admitted to hospital.
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8 9 **Methods**

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11 This qualitative study is based on focus group interviews and grounded theory.^{30 31} This method
12
13 was combined with an individual questionnaire soliciting demographic data, as well as questions
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15 and statements based on barriers to participation, such as short in-care time or the patient being
16
17 too ill to participate in medical decision making.^{25 32}
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20 21 **Setting and participants**

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23 The participants were hospital physicians in departments of geriatrics, general and orthopaedic
24
25 surgery, and internal medicine in two counties in Sweden. For demographics of the physicians,
26
27 please see Table 1. Each focus group interview had six participants, and in total, thirty physicians
28
29 in three different hospitals were interviewed. The departments were chosen for having a high
30
31 proportion of elderly patients on their wards and represented several medical specialities. The
32
33 first author (AE) is a geriatrician with more than 20 years' experience of geriatric medicine and
34
35 is used to discussing participation in medical decision making with patients and relatives. The
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37 last author (MF) is a nurse with experience in research and nursing in palliative care. Both the
38
39 first and last author conducted all interviews.
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45 46 **Data collection**

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48 A semi-structured interview guide was developed based on earlier studies,^{25 32} the researchers'
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50 experiences, and discussions with fellow physicians. For the complete questionnaire please see
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52 Table 2. The interview guide was used when needed to ensure that key areas were discussed, and
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54 it was modified as interviews progressed to accommodate probing questions. Interviews with
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3 physicians were conducted between April 2010 and May 2011 and were performed in
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5 department conference rooms at a time chosen by the physicians. At the beginning of each
6
7 interview, an investigator (MF or AE) introduced the study and explained the focus group's
8
9 objectives and process. Both investigators participated in each focus group interview; one took a
10
11 more active role, the other more of an observer. The interviews, approximately an hour in length,
12
13 were tape recorded and transcribed verbatim by the first author. The informants were asked to
14
15 share their thoughts on elderly patients with multimorbidity and describe perceived barriers and
16
17 facilitators to participation.
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21 Data collection and analysis went on until no new categories emerged and no new properties
22
23 within the categories were identified. A self-administered questionnaire was collected at the end
24
25 of each focus group (to avoid having the questions influence the interview), in which the
26
27 physicians were asked to estimate the percentage of the presence of different barriers with impact
28
29 on participation in medical decision making; they were also asked to choose the most appropriate
30
31 of four different statements regarding informing elderly patients about their treatment.
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35 Field notes were recorded immediately after each interview, including descriptions of where the
36
37 interview was held, reflections on how the interview went to get a deeper understanding of what
38
39 was going on, and what the physicians were describing.
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43 **Data analysis**

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45 First, there was an initial coding whereby we gave substantive names to text sequences and
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47 developed preliminary categories. The next step involved asking questions about what was going
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49 on and making constant comparisons between and within the preliminary categories to see if the
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51 categories were well described. The aim was to obtain a focused coding, using the most
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53 significant earlier preliminary codes to synthesise and explain larger segments of data.^{30 31} At
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3 the same time, an axial coding was performed to bring back data together and describe the
4
5 categories.^{30 31} Data collection and data analysis were performed simultaneously. Integrative
6
7 diagrams and memos were written throughout the process to guide thinking and to record
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9 analytical insights and interpretations.
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12 **Rigour**

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16 At the end of each interview, one of the authors summarised the discussion for the focus group,
17
18 to ensure that there were no misunderstandings. All physicians confirmed the summary. Several
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20 data collection methods were used in order to study the phenomenon from different aspects. The
21
22 quantitative results were not analysed until all interviews had been done. Two researchers (MF
23
24 and AE) initially did the coding independently. A third independent researcher experienced with
25
26 grounded theory (IH) reread and interpreted the findings. Regular meetings were held to review
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28 the evolving understanding.
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35 **Findings**

36 **Quantitative results**

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42 Twenty-nine physicians answered a questionnaire about the proportion of their frail elderly
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44 patients to whom different statements about barriers affecting participation in medical decision
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46 making applied. The results are shown in Table 3. As can be seen, the physicians assumed that
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48 most patients were not too ill to participate in medical decision making; for more results, please
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50 see the table.
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3 In the same questionnaire the physicians were asked to choose the most appropriate of four
4 statements regarding elderly patients' information about their treatment, and 23 (79%) of the
5 physicians responded. Of the responders, seven (30%) believed that patients got the information
6 they wanted about their treatment, eight (35%) that patients would have preferred more
7 information, seven (30%) that patients found it difficult to ask questions about their treatment,
8 and one (4%) that the patients did not want to know about their treatment.
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18 **Qualitative results**

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21 In the interviews we identified two categories describing physicians' thoughts on participation in
22 medical decision making of elderly patients with multimorbidity. The first category was called
23 "being challenged," which meant meeting the challenge to take care of elderly patients with
24 multimorbidity in all its complexity. The second category was called "being a small part of the
25 health care production machine," with its bureaucratic routines and remuneration systems that do
26 not favour elderly patients with multimorbidity. Both categories were leading to the core
27 category "lacking in time."
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38 For an overall integrative diagram of physicians' thoughts on elderly patients with comorbidity,
39 please see Figure 1.
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43 Throughout the interviews the physicians described why they could not give good care to these
44 patients, and the overall theory explaining physicians' experiences of elderly patients with
45 multimorbidity was that it was "too complex and time-consuming to fit in!" mostly because of
46 lack of competence or lack of a holistic view, but also because the routines in the hospital care
47 system, and the remuneration system, do not favour elderly patients with multimorbidity.
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Being challenged

To take care of elderly patients with multimorbidity and make them participate in medical decision making was described as a challenge. This was explained by the patients' medical and social complexity and their need of time-consuming communication with all caregivers, including relatives, which gave physicians the feeling of not being able to provide a good quality of care. Other challenging circumstances included patients not clearly expressing their preferences and communicating with patients with cognitive decline.

Having a feeling of incompetence

Physicians—apart from the geriatricians—described a feeling of not having the right competence for this patient group. They reported a lack of a holistic view, insufficient knowledge of medications, lack of competence regarding social needs, and difficulties in communicating with the municipality, whose rules they did not understand and which they viewed as overly bureaucratic.

I: What do you think of the frail elderly as patients?

R1: An old patient with many illnesses and polypharmacy. And what do we know of the long medication list? How many interactions do we miss? We do one thing at a time and do not care about the whole.

R2: We meet them quite often; well, they are in our care system all the time, but sometimes we feel a bit stranded and do not know what to do with them.

These patients were described as being frequently admitted without a diagnosis, but rather because of vague symptoms of “getting worse.” All physicians agreed that the frail elderly are time consuming compared to other patients. They reported a feeling of not doing a good job due to lack of time. Furthermore, it was expressed as being sometimes quicker to order investigations

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3 or give treatments than to take time to discuss goal setting, consequences of investigations, pros
4 and cons of treatments, and to have a more thorough discussion of the whole situation.
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8 The patients are also in need of nursing care, which is not the main focus of the doctors.
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10 Physicians described themselves as doing “nothing” when taking care of the elderly, who were
11 seen as taking time from patients with distinctive, acute medical conditions.
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15 *R: We want to do elective care—that makes good statistics. We can't have these frail elderly in*
16 *need of nursing care, and on top of all, we don't really know how to take care of them or how to*
17 *treat them medically, so they are totally worthless to us.*
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21 A challenge arises when patients prefer a passive or subordinate role, leaving a greater
22 responsibility to the doctors to make decisions. Many physicians were uncomfortable with
23 having to try to guess the preferences of the patients—and again—it can be time-consuming.
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28 *Having to take relatives into consideration*
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30 Relatives are described as both an asset and a hindrance to good care and participation in medical
31 decision making. Sometimes they act as an extra set of ears, able to ask questions and harbour
32 information for a patient who is in poor condition and currently cannot assimilate medical facts.
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36 At other times, physicians feel that relatives are “taking over,” pressing for investigations and
37 treatments that are medically unbeneficial for the patient or against the patient’s preferences.
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40 Below is an example of family members opposing information being passed to the patient,
41 impeding the patient’s own participation and creating an ethical dilemma for the physicians
42 concerning whom to listen to.
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49 *I: You have now told me about barriers to patient participation, such as routines. Do you see*
50 *other problems?*
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53 *R: Relatives (from several physicians at a time).*
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56 *I: That came fast—tell me more.*
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3 *R: Like when the mother is very ill, and the relatives do not allow her to be informed. They wish to*
4 *protect her from knowing the truth.*
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7 At the same time, physicians pointed out the importance of following the wishes of the patients,
8
9 of not letting relatives take over making medical decisions and becoming the only ones
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11 addressed by health care staff.
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14 *Having to take cognitive decline into account*

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16 To make patients participate in medical decision making, physicians have to give information
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18 adapted to the patients' medical condition, educational level, and not least, cognitive functions,
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20 the latter being a common problem in this group. It is important to give time, listen carefully, be
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22 polite, and establish a relationship, by trying to understand what is important for the patient,
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24 finding out what the patient's fears and preferences are. All this has to be done within a quite
25
26 limited time frame.
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31 The high prevalence of cognitive decline in elderly patients is giving relatives a bigger role in
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33 medical decision making compared to that needed for younger patients, necessitating
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35 communication with more people, who are not always accessible, again requiring more time than
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37 other groups of patients.
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41 **Being a small piece of the “health care production machine”**

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43 To be part of the health care production machine means to be part of the hospital with all its
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45 routines, including communication and remuneration systems, which are badly adapted to elderly
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47 patients with multimorbidity. It also means dealing with a lack of beds and continuity, especially
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49 among physicians.
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3 The participating physicians who worked in emergency departments made certain observations.
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5 The emergency room was described as a kind of machine “sucking in” patients, with routines set
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8 up to start investigations, make diagnoses and admit patients, rather than send them home. Some
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10 expressed that elderly patients with multimorbidity were taking time and space from the really
11
12 acutely ill patients. Multiple illnesses in one patient make it difficult to admit them to a specific
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14 department or ward, and they were described as “hanging in the air between specialties” before
15
16 finally being admitted somewhere.
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18 *At the mercy of routines*

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20 Rigid ward routines lead to difficulties in giving individualised care. Physicians describe
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22 themselves as having little or no influence over these routines. The premises are described as
23
24 noisy, frequently without adequate places or chairs for a calm conversation in a dignified
25
26 environment. Much communication on the wards happens not directly with the patient, but
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28 through nurses and assistant nurses, and they cannot always be sure they have got the correct
29
30 information about the patient:
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36 *R: You must often trust the information from nurses and assistant nurses—you don't have the*
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38 *time to talk with the patient. And often it is not even the nurse that talked to the patient herself—it*
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40 *could be the nurse from a previous shift. Very often this is the source of information—and it is not*
41
42 *always correct!*
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44 Physicians felt that the rapid turnover of staff, including doctors, on the wards made it difficult to
45
46 get to know elderly patients and their illnesses, resulting in a lack of continuity of care. This had
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48 greater impact on these patients, who commonly have a longer in-care time. Lack of beds and
49
50 time coalesced into speedy, not uncommonly premature, discharges.
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53 *Inadequate remuneration system*

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3 The remuneration system favours easy accessibility and a high number of treated patients,
4 making elderly patients with long in-care time an obstacle to good economy and “worthless” as
5 cited earlier, at the same time as physicians recognize their needs. Hence, these patients are not
6 allotted enough time for good care, including time for participation in medical decision making.
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12 As these physicians pointed out:

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15 *R: It is not a good system we have created, not making the frail elderly feel welcome. I think that*
16 *many of these patients feel unwelcome, because they are regarded by us physicians as just a*
17 *cost. You are educated as a physician to take care of people, but you end up with the “knife in*
18 *your back”—it is not good.*
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23 The physicians felt a frustration that “money rules,” creating ethical dilemmas when everyone is
24 trying to avoid these patients, in spite of their needs.
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28 29 **They just don't fit in**

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32 The overall theory generated by our data was that due to lack of competence, lack of a holistic
33 view, need of time-consuming care and communication with multiple caregivers, an inadequate
34 remuneration system, and inappropriate routines, elderly patients with multimorbidity are too
35 complex and time-consuming to fit in at the hospital, with severe obstacles to their participation
36 in medical decision making.
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45 **Discussion**

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47 The main findings of this study show ideals conflicting with reality. It is difficult for a physician
48 who is not familiar with all diseases and treatment options to invite a patient to participate in
49 medical decision making. To take good care of these patients requires consultations and referrals
50 to multiple specialists, and as the physicians point out, there is no time to do these. The
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3 alternative is to partly ignore illnesses where the competence to address, eliciting a feeling of
4 inadequacy, is lacking. Elderly patients with multimorbidity indeed form a complex patient
5 group and integration of their care is a central challenge for health care delivery.³³ The increase
6 in medical knowledge and skills has resulted in increasing specialisation, making it more
7 difficult to have the necessary holistic view regarding elderly patients with multimorbidity.
8 Much of the content of the interviews revolved around physicians explaining why they were not
9 able to provide these patients with good care and enable them to participate in medical decision
10 making. Physicians expressed feelings of frustration and bad conscience about not being able to
11 prioritise these patients; at the same time, some of the physicians expressed that elderly patients
12 were not ill enough to be in hospital, taking beds and time from the “really ill” patients. We
13 know that there is a six-month mortality rate of around 25% in elderly patients who have been
14 emergently admitted during the previous six months.³⁴ Thus, these patients really are ill—but
15 still not always welcome in a hospital.

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34 As the system of remuneration is linked to “health care production,” such as rapid accessibility
35 (i.e. time to investigations or operations) and number of treated patients, the geriatric way of
36 working is driven out of competition. Lack of geriatric competence, with the geriatrician’s
37 specific skills in comprehensive geriatric assessment, holistically combining physical,
38 psychological, social, and functional perspectives, is a main area of concern in the care of elderly
39 patients with multimorbidity, with consequences such as higher dependency after discharge and
40 higher mortality.³⁵ In spite of political announcements on the importance of taking good care of
41 elderly patients with multimorbidity, the remuneration systems continue to emphasise easy
42 accessibility, rapid turnover, and focus on reduced time consumption, all of which hinder
43 physicians from meeting these patients’ needs.

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3 The quantitative results presented in the tables all support the qualitative findings.
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6 **Limitations**

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9 Although the mainly qualitative methodology in this study limits generalisation and is restricted
10 to the health care system and the geographical context in Sweden, our findings still provide
11 insight into the problem of the decision making process of elderly patients with multimorbidity.
12 The range of specialities among the interviewed physicians increases the validity of our results.
13 There are similarities and differences in all countries remunerations systems and attitudes to the
14 elderly which also limit generalisations.
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24 **Conclusion**

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28 We describe important obstacles to participation in medical decision making by elderly patients
29 with multimorbidity, such as physicians' lack of geriatric competence and lack of time. The
30 remuneration systems do not allow for necessary time for communication between medical
31 professionals and between physicians and patients/relatives. Neither do they support the
32 necessary integration of care. Thus, taking care of elderly patients with multimorbidity often
33 frustrates physicians by giving them a feeling of professional inadequacy, as they are unable to
34 prioritise this common and rapidly growing patient group. This indicates that hospital care is not
35 adapted to the elderly with multimorbidity which are a highly complex patient group to take care
36 of. This has not been clearly documented in earlier studies, and is important to bear in mind
37 when planning for future health care, especially as there will be a growing proportion of frail
38 elderly people.
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Figure legends

Table 1: Demographics of the doctors

Table 2: Semi-structured interview guide

Table 3: Doctors' estimation of different barriers affecting participation in medical decision making

Figure 1: Physicians' thoughts on elderly patients with multimorbidity

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Ethical considerations

All doctors who participated in the interviews were informed about the aim of the study and that all participation was voluntary. They were also informed that the interviews should result in an article and that it should not be possible to connect specific statements to a named person.

Authors' contributions

AE drafted the manuscript, LA and MF participated in the design of the study, and IH performed the qualitative analysis together with AE and MF. All authors read and approved the final manuscript.

Statement

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Competing interests

All authors have completed the Unified Competing Interest form and declare that all authors had:

(1) No financial support for the submitted work from anyone other than their employer; (2) No financial relationships with commercial entities that might have an interest in the submitted work; (3) No spouses, partners, or children with relationships with commercial entities that

Lacking in time

Being challenged

- Having a feeling of incompetence
- Having to take relatives into consideration
- Having to take cognitive decline into account

Being a small part of the health care machinery

- At the mercy of routines
 - Unfit premises
 - Indirect communication
 - Lack of continuity
 - Lack of beds
- Inadequate remuneration for elderly with comorbidity

Figure 1: Physicians' thoughts on elderly patients with multimorbidity

Table 1 Demographics of the doctors

Women/men (N = 29)	10/19
Age groups (N = 27)	
<35 yr	7
35–45 yr	3
46–55 yr	7
>55 yr	10
Years of experience (N = 29)	
<5 yr	6
5–10 yr	3
11–20 yr	7
>20 yr	13

Table 2 Semi-structured interview guide

INTRODUCTORY QUESTION	Tell us a word or image that comes into your mind when you think about the frail elderly.
TRANSITION QUESTION	Tell us what comes into your mind when you think about patient participation in treatment decision making.
KEY QUESTION	What ingredients do you think are necessary to achieve patient participation in treatment decision making?
KEY QUESTION	Which role (active, shared, passive) do you think that frail elderly patients prefer in treatment decision making?
KEY QUESTION	How do you think you could facilitate communication between the frail elderly and health care staff (or doctors)?
KEY QUESTION	How do you think we meet the preferences of the frail elderly regarding information about their health care?
KEY QUESTION	What obstacles to participation in treatment decision making do you think are faced by the frail elderly?
KEY QUESTION	What obstacles in the organization of health care do you think exist to participation in treatment decision making by the frail elderly?
FINAL QUESTION	Is there anything else that anyone feels we should have talked about?
	Summarising and verification.

Table 3 Doctors' estimation of different barriers affecting participation in medical decision making

To what proportion of your frail elderly patients do the following statements apply? (N = 29)	
Perceive to be too ill to participate in medical decision making:	No of Doctors (%)
0–20%	15 (52%)
21–40%	10 (34%)
41–60%	4 (14%)
61–80%	-
81–100%	-
Perceive different treatment strategies between different doctors:	
0–20%	5 (17%)
21–40%	12 (41%)
41–60%	5 (17%)
61–80%	6 (21%)
81–100%	1 (3%)
Perceive to have too short in-care time to participate in medical decision making:	
0–20%	1 (3%)
21–40%	5 (17%)
41–60%	5 (17%)
61–80%	10 (34%)
81–100%	8 (28%)
Perceive to have difficulties in understanding the medical information you give them:	
0–20%	-
21–40%	6 (21%)
41–60%	10 (34%)
61–80%	9 (31%)
81–100%	3 (10%)



**Too complex and time-consuming to fit in!
Physicians' experiences of elderly patients and their
participation in medical decision making: a grounded theory
study**

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5 Physicians' experiences of elderly patients and their participation in medical decision making: a
6 grounded theory study
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52 Word Count: 3350
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Abstract

Objective

To explore physicians' thoughts and considerations of participation in medical decision making by hospitalised elderly patients.

Design

A qualitative study using focus group interviews with physicians interpreted with grounded theory and completed with a questionnaire.

Setting and participants

The setting was three different hospitals in two counties in Sweden. Five focus groups were conducted with physicians ($n = 30$) in medical departments, with experience of care of elderly patients.

Results

Physicians expressed frustration at not being able to give good care to elderly patients with multimorbidity, including letting them participate in medical decision making. Two main categories were found: 'being challenged' by this patient group and 'being a small part of the health care production machine'. Both categories were explained by the core category 'lacking in time'. The reasons for the feeling of being challenged were explained by the subcategories 'having a feeling of incompetence', 'having to take relatives into consideration' and 'having to take cognitive decline into account'. The reasons for the feeling of 'being a small part of the health care production machine' were explained by the subcategories 'At the mercy of routines' and 'inadequate remuneration system' both of which do not favour elderly patients with multimorbidity.

1
2
3 Conclusions

4
5 **Physicians find that elderly patients with multimorbidity lead to frustration** by giving them
6
7 a feeling of professional inadequacy, as they are unable to prioritise this common and rapidly
8
9 growing patient group and enable them to participate in medical decision making. The reason for
10
11 this feeling is explained **by lack of time, competence, holistic view, appropriate routines, and**
12
13 **proper remuneration systems for treating these patients.**
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16 17 18 19 Article summary

20 21 Article focus:

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23 **Physicians' views and attitudes to elderly patients' participation in medical decision**
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25 **making**

26 27 Key messages:

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29 Hospital care is not well adapted to the elderly with multimorbidity as they are a highly complex
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31 patient group to take care of.
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35 Taking care of elderly patients with multimorbidity often frustrates physicians by giving them a
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37 feeling of professional inadequacy.
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41 Remuneration systems do not allow for necessary time for communication among medical
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43 professionals and between physicians and patients or relatives. Neither do these systems support
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45 the necessary integration of care.
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48 49 Strengths and limitations:

50 51 Strengths:

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53 The scope of the study, to the authors' knowledge, has not been clearly documented in earlier
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55 studies and is important to bear in mind when planning for future health care, especially as there
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57 will be a growing proportion of frail elderly people.
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3 Limitations:
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5 Qualitative research limits generalization.
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8 The study was performed in a Swedish context.
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Introduction

Health care professionals have a responsibility to involve patients in medical decision making. This has been accepted as ethically appropriate practice for decades and is a part of health care legislation in many countries.¹⁻⁵ The literature supports the advantages of patient participation is to give better treatment results and higher patient satisfaction.⁶⁻¹²

Studies in the area of medical decision making show that most patients prefer shared decision making, but that preferences are very individual.¹³ Several factors have influence, such as age, sex and level of education, but the relationship is not constant.¹⁴⁻¹⁷ Several studies have focused on older patients with cancer and chronic diseases.^{14-16 18 19} Most have found a decline in the wish for involvement as patients get older^{17 20-24}; nevertheless, studies have shown that, overall, there is less participation than actually preferred.^{25 26} One of the reasons reported for not participating is the patient feeling subordinate to the hospital as an institution of power.²⁷

In contrast to the multitude of publications on patient participation, there is a lack of studies of physicians' preferences and behaviour related to stimulating patients to partake in decision making.²⁸ Some studies have shown that attitudes towards involving patients range from highly positive to more circumspect, and that moves towards enhancing patient involvement in decision making will depend on developing both the skills and attitudes of medical professionals.^{21 29} Further influence is exerted by the conflict of demands on resources within the collectively funded health care system³⁰ and the lack of time.³¹

In summary, we know much about the benefits of patient participation in medical decision making and something about the elderly and their preferences related to this process. However,

1
2
3 very little is known about physicians' thoughts and considerations regarding patient
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5 participation, particularly among elderly patients. The aim of this study is to explore physicians'
6
7 thoughts and considerations of participation in medical decision making by hospitalised elderly
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9 patients with multimorbidity who are admitted to hospital.
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12 13 14 **Methods**

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17 This qualitative study is based on focus group interviews and grounded theory.^{32 33} This method
18
19 was combined with an individual questionnaire soliciting demographic data, as well as questions
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21 and statements based on barriers to participation, such as short in-care time or the patient being
22
23 too ill to participate in medical decision making.^{25 27}
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25

26 **Setting and participants**

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28 The participants were hospital physicians in departments of geriatrics, general and orthopaedic
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30 surgery, and internal medicine in two counties in Sweden. We performed one interview in each
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32 department in which there were six doctors. Each session took about an hour. For the
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34 demographics of the physicians, see Table 1. Each focus group interview had six participants,
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36 and in total, thirty physicians in three different hospitals were interviewed. The departments were
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38 chosen for having a high proportion of elderly patients on their wards and represented several
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40 medical specialities. The first author of this study (AE) is a geriatrician with more than 20 years'
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42 experience of geriatric medicine and is used to discussing participation in medical decision
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44 making with patients and relatives. The last author (MF) is a nurse with experience in research
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46 and nursing in palliative care. Both of these authors were present at each interview .
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52 **Data collection**

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54 A semi-structured interview guide was developed based on earlier studies,^{27 34} the researchers'
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56 experiences, and discussions with fellow physicians. For the complete questionnaire, see Table 2.
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3 The interview guide was used when needed to ensure that key areas were discussed, and it was
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5 modified as interviews progressed to accommodate probing questions. Interviews with
6
7 physicians were conducted between April 2010 and May 2011 and were performed in
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9 department conference rooms at a time chosen by the physicians. At the beginning of each
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11 interview, an investigator (MF or AE) introduced the study and explained the focus group's
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13 objectives and process. Both investigators participated in each focus group interview; one took a
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15 more active role, the other was more of an observer. The interviews, approximately an hour in
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17 length, were tape-recorded and transcribed verbatim by the first author. The informants were
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19 asked to share their thoughts on elderly patients with multimorbidity and to describe perceived
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21 barriers and facilitators to participation.
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29 Data collection and analysis continued until no new categories emerged and no new properties
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31 within the categories were identified. A self-administered questionnaire was collected at the end
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33 of each focus group (to avoid having the questions influence the interview), in which the
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35 physicians were asked to estimate the percentage of the presence of different barriers with impact
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37 on participation in medical decision making; they were also asked to choose the most appropriate
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39 of four different statements regarding informing elderly patients about their treatment.
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46 Field notes were recorded immediately after each interview, including descriptions of where the
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48 interview was held, reflections on how the interview went to get a deeper understanding of what
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50 was going on, and what the physicians were describing.
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Data analysis

First, there was an initial coding whereby we gave substantive names to text sequences and developed preliminary categories. The next step involved asking questions about what was going on and making constant comparisons between and within the preliminary categories to see if the categories were well described. The aim was to obtain a focused coding, using the most significant earlier preliminary codes to synthesise and explain larger segments of data.^{32 33} At the same time, an axial coding was performed to bring data together and describe the categories.^{32 33} Data collection and data analysis were performed simultaneously. Integrative diagrams and memos were written throughout the process to guide thinking and to record analytical insights and interpretations.

Rigour

At the end of each interview, one of the authors summarised the discussion for the focus group, to ensure that there were no misunderstandings. All physicians confirmed the summary. Several data collection methods were used in order to study the phenomenon from different aspects. The quantitative results were not analysed until all interviews had been completed. Two researchers (MF and AE) did the initial coding independently. A third independent researcher experienced with grounded theory (IH) reread and interpreted the findings. Regular meetings were held to review the evolving understanding.

Findings

Quantitative results

Twenty-nine physicians (of totally thirty) answered a questionnaire about the proportion of their frail elderly patients to whom different statements about barriers affecting participation in medical decision making applied. The results are shown in Table 3. As can be seen, the physicians assumed that most patients were not too ill to participate in medical decision making. In the same questionnaire the physicians were asked to choose the most appropriate of four statements regarding elderly patients' information about their treatment, and 23 (79%) of the physicians responded. Of the responders, seven (30%) believed that patients got the information they wanted about their treatment, eight (35%) that patients would have preferred more information, seven (30%) that patients found it difficult to ask questions about their treatment, and one (4%) that the patients did not want to know about their treatment.

Qualitative results

In the interviews we identified two categories describing physicians' thoughts on participation in medical decision making of elderly patients with multimorbidity. The first category was called "being challenged," which meant meeting the challenge to take care of elderly patients with multimorbidity in all its complexity. The second category was called "being a small part of the health care production machine," with its bureaucratic routines and remuneration systems that do not favour elderly patients with multimorbidity. Both categories led to the core category "lacking in time." For an integrative diagram of physicians' thoughts on elderly patients with multimorbidity, see Table 4.

1
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3 Throughout the interviews the physicians described why they could not give good care to these
4 patients, and the overall theory explaining physicians' experiences of elderly patients with
5 multimorbidity was that it was "too complex and time-consuming to fit in", mostly because of
6 lack of competence or lack of a holistic view, but also because the routines in the hospital care
7 system and in the remuneration system, do not favour elderly patients with multimorbidity.
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14 15 16 17 18 Being challenged

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20 To take care of elderly patients with multimorbidity and enable them to participate in medical
21 decision making was described as a challenge. This was explained by the patients' medical and
22 social complexity and their need of time-consuming communication with all caregivers,
23 including relatives, which gave physicians the feeling of not being able to provide a good quality
24 of care. Other challenging circumstances included patients not clearly expressing their
25 preferences and communicating with patients with cognitive decline.
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36 37 38 Having a feeling of incompetence

39 Physicians—apart from the geriatricians—described a feeling of not having the right competence
40 for this patient group. They reported a lack of a holistic view, insufficient knowledge of
41 medications, lack of competence regarding social needs and difficulties in communicating with
42 the municipality, whose rules they did not understand and which they viewed as overly
43 bureaucratic.
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50 I: What do you think of the frail elderly as patients?
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3 R1: [Consider] an old patient with many illnesses and polypharmacy... What do we know of the
4 long medication list? How many interactions do we miss? We do one thing at a time and do not
5 care about the whole.
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10 R2: We meet them quite often; well, they are in our care system all the time, but sometimes we
11 feel a bit stranded and do not know what to do with them.
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13 These patients were described as being frequently admitted without a diagnosis, but rather
14 because of vague symptoms of “getting worse”. All physicians agreed that the frail elderly are
15 time-consuming compared to other patients. They reported a feeling of not doing a good job due
16 to lack of time. Furthermore, it was expressed as being sometimes quicker to order investigations
17 or give treatments than to take time to discuss goal setting, consequences of investigations, pros
18 and cons of treatments or having a more thorough discussion of the whole situation.
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30 The patients are also in need of nursing care, which is not the main focus of the doctors.
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32 Physicians described themselves as doing “nothing” when taking care of the elderly, who were
33 seen as taking time from patients with distinctive, acute medical conditions.
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39 R: We want to provide elective care—that makes good statistics. We can’t have these frail
40 elderly in need of nursing care, and on top of all, we don’t really know how to take care of them
41 or how to treat them medically, so they are totally worthless to us.
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46 A challenge arises when patients prefer a passive or subordinate role, leaving a greater
47 responsibility to the doctors to make decisions. Many physicians were uncomfortable with
48 having to try to guess the preferences of the patients—and again—it could be time-consuming.
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55 Having to take relatives into consideration
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Relatives are described as both an asset and a hindrance to good care and participation in medical decision making. Sometimes they act as an extra set of ears, able to ask questions and harbour information for a patient who is in poor condition and currently cannot assimilate medical facts.

At other times, physicians feel that relatives are “taking over”, pressing for investigations and treatments that are medically unbeneficial for the patient or against the patient’s preferences. The following is an example of family members opposing information being passed to the patient, impeding the patient’s own participation and creating an ethical dilemma for the physicians concerning whom to listen to:

I: You have just told me about barriers to patient participation, such as routines. Do you see other problems?

R: Relatives (from several physicians at a time).

I: That came fast—tell me more.

R: Like when the mother is very ill, and the relatives do not allow her to be informed. They wish to protect her from knowing the truth.

At the same time, physicians pointed out the importance of following the wishes of patients, of not letting relatives take over making medical decisions and becoming the only ones addressed by health care staff.

Having to take cognitive decline into account

To enable patients to participate in medical decision making, physicians have to give information adapted to the patients’ medical condition, educational level, and not least, cognitive function, the latter being a common problem in this group. It is important to allot time, listen carefully, be polite, and establish a relationship by trying to understand what is important for the patient,

1
2
3 finding out what the patient's fears and preferences are. All this has to be done within a quite
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5 limited time frame.
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10 The high prevalence of cognitive decline in elderly patients is giving relatives a bigger role in
11
12 medical decision making compared to that needed for younger patients, necessitating
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14 communication with more people, who are not always accessible, again requiring more time than
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16 other groups of patients.
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19

20 21 **Being a small piece of the “health care production machine”** 22 23

24 To be part of the health care production machine means to be part of the hospital with all its
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26 routines, including communication and remuneration systems, which are badly adapted to elderly
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28 patients with multimorbidity. It also means dealing with a lack of beds and continuity, especially
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30 among physicians.
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36 The participating physicians who worked in emergency departments made certain observations.
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38 The emergency room was described as a kind of machine “sucking in” patients, with routines set
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40 up to start investigations, make diagnoses and admit patients, rather than send them home. Some
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42 indicated that elderly patients with multimorbidity were taking time and space from the really
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44 acutely ill patients. Multiple illnesses in one patient made it difficult to admit them to a specific
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46 department or ward, and they were described as “hanging in the air between specialties” before
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48 finally being admitted somewhere.
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54 At the mercy of routines
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3 Rigid ward routines lead to difficulties in giving individualised care. Physicians describe
4 themselves as having little or no influence over these routines. The premises are described as
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Rigid ward routines lead to difficulties in giving individualised care. Physicians describe themselves as having little or no influence over these routines. The premises are described as noisy, frequently without adequate places or chairs for a calm conversation in a dignified environment. Much communication on the wards happens not directly with the patient, but through nurses and assistant nurses, and the physicians cannot always be sure they have got the correct information about the patient:

R: You must often trust the information from nurses and assistant nurses—you don't have the time to talk with the patient. And often it is not even the nurse that talked to the patient herself—it could be the nurse from a previous shift. Very often this is the source of information—and it is not always correct!

Physicians felt that the rapid turnover of staff, including doctors, on the wards made it difficult to get to know elderly patients and their illnesses, resulting in a lack of continuity of care. This had greater impact on these patients, who commonly have a longer in-care time. Lack of beds and time coalesced into speedy, not uncommonly premature, discharges.

Inadequate remuneration system

The remuneration system favours easy accessibility and a high number of treated patients, making elderly patients with long in-care time an obstacle to good economy and “worthless” as cited earlier, at the same time as physicians recognize their needs. Hence, these patients are not allotted enough time for good care, including time for participation in medical decision making.

As these physicians pointed out:

R: It is not a good system we have created, not making the frail elderly feel welcome. I think that many of these patients feel unwelcome, because they are regarded by us physicians as just a cost.

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3 You are educated as a physician to take care of people, but you end up with the “knife in your
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7 back”—it is not good.

8 The physicians felt a frustration that “money rules,” creating ethical dilemmas when everyone is
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10
11 trying to avoid these patients, in spite of their needs.

14 **They just don’t fit in**

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17 The overall theory generated by our data was that due to lack of competence, lack of a holistic
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The overall theory generated by our data was that due to lack of competence, lack of a holistic view, need for time-consuming care and communication with multiple caregivers, an inadequate remuneration system, and inappropriate routines, elderly patients with multimorbidity are too complex and time-consuming to fit in at the hospital, with severe obstacles to their participation in medical decision making.

30 **Discussion**

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33 The main findings of this study show ideals conflicting with reality. It is difficult for a physician
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The main findings of this study show ideals conflicting with reality. It is difficult for a physician who is not familiar with all diseases and treatment options to invite a patient to participate in medical decision making. To take good care of these patients requires consultations and referrals to multiple specialists, and as the physicians point out, there is no time to do these. The alternative is to partly ignore illnesses where the competence to address the situation is lacking, eliciting a feeling of inadequacy. Elderly patients with multimorbidity indeed form a complex patient group, and integration of their care is a central challenge for health care delivery.³⁴ The increase in medical knowledge and skills has resulted in increasing specialisation, making it more difficult to have the necessary holistic view regarding elderly patients with multimorbidity. Much of the content of the interviews revolved around physicians explaining why they were not able to provide these patients with good care and enable them to participate in medical decision

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3 making. Physicians expressed feelings of frustration and bad conscience about not being able to
4 prioritise these patients; at the same time, some of the physicians observed that elderly patients
5 were not ill enough to be in hospital, taking beds and time from the “really ill” patients. We
6 know that there is a six-month mortality rate of around 25% in elderly patients who have been
7 emergently admitted during the previous six months.³⁵ Thus, these patients really are ill—but
8 still not always welcome in a hospital. The issue is whether the physicians’ lack of giving
9 priority to the elderly with multimorbidity is more an expression of ageism³⁶, not finding it
10 interesting or attractive to take care of these patients and finding it more convenient to blame the
11 lack of time rather than admit a lack of interest.
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27 As the system of remuneration is linked to “health care production”, such as rapid accessibility
28 (i.e. time taken to perform investigations or operations) and number of treated patients, the
29 geriatric approach to treatment assumes a lower priority. Lack of geriatric competence,
30 specifically the specialist’s skills in comprehensive geriatric assessment, holistically combining
31 physical, psychological, social, and functional perspectives, is a main area of concern in the care
32 of elderly patients with multimorbidity, with consequences such as higher dependency after
33 discharge and higher mortality.³⁷ In spite of political announcements on the importance of taking
34 good care of elderly patients with multimorbidity, the remuneration systems continue to
35 emphasise easy accessibility, rapid turnover, and focus on reduced performance time, all of
36 which hinder physicians from meeting these patients’ needs.
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53 The quantitative results presented in the tables all support the qualitative findings.
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55 **Limitations**

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3 Although the mainly qualitative methodology in this study limits generalisation and is restricted
4 to the health care system and the geographical context of Sweden, our findings do provide
5 insight into the problem of the decision making process of elderly patients with multimorbidity.
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7 The range of specialities among the interviewed physicians increases the validity of our results.
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9 There are similarities and differences in all countries' remunerations systems and attitudes to the
10 elderly, which also limit generalisations.
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19 Conclusion

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21 We describe important obstacles to participation in medical decision making by elderly patients
22 with multimorbidity, such as physicians' lack of geriatric competence and lack of time. The
23 remuneration systems do not allow for necessary time for communication between medical
24 professionals and between physicians and patients or relatives. Neither do they support the
25 necessary integration of care. Thus, taking care of elderly patients with multimorbidity often
26 frustrates physicians by giving them a feeling of professional inadequacy, as they are unable to
27 prioritise this common and rapidly growing patient group. This indicates that hospital care is not
28 adapted to the elderly with multimorbidity, who are a highly complex patient group to take care
29 of. This has not been clearly documented in earlier studies but is important to bear in mind when
30 planning for future health care, especially as there will be a growing proportion of frail elderly
31 people.
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Figure legends

Table 1: Demographics of the physicians

Table 2: Semi-structured interview guide

Table 3: Physicians' estimation of barriers affecting participation in medical decision making

Table 4: Physicians' thoughts on elderly patients with multimorbidity

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Ethical considerations

All doctors who participated in the interviews were informed about the aim of the study and that all participation was voluntary. They were also informed that the interviews would result in an article and that it would not be possible to connect specific statements to a named person.

Authors' contributions

AE drafted the manuscript, LA and MF participated in the design of the study, and IH performed the qualitative analysis together with AE and MF. All authors read and approved the final manuscript which was then given a final review by an English language editor."

Statement

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8 9 **Competing interests**

10 All authors have completed the Unified Competing Interest form and declare that all authors had:

11
12 (1) No financial support for the submitted work from anyone other than their employer; (2) No
13
14 financial relationships with commercial entities that might have an interest in the submitted
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16 work.
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20 21 **Data sharing statement**

22 Extra data (interviews in full-text) is available by emailing anne.ekdahl@lio.se
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Table 1 Demographics of the physicians.

Women/men (N = 29)	10/19
Age groups (N = 27)	
<35 yr	7
35–45 yr	3
46–55 yr	7
>55 yr	10
Years of experience (N = 29)	
<5 yr	6
5–10 yr	3
11–20 yr	7
>20 yr	13

Table 2 Semi-structured interview guide

INTRODUCTORY QUESTION	Tell us a word or image that comes into your mind when you think about the frail elderly.
TRANSITION QUESTION	Tell us what comes into your mind when you think about patient participation in treatment decision making.
KEY QUESTION	What ingredients do you think are necessary to achieve patient participation in treatment decision making?
KEY QUESTION	Which role (active, shared, passive) do you think that frail elderly patients prefer in treatment decision making?
KEY QUESTION	How do you think you could facilitate communication between the frail elderly and health care staff (or doctors)?
KEY QUESTION	How do you think we meet the preferences of the frail elderly regarding information about their health care?
KEY QUESTION	What obstacles to participation in treatment decision making do you think are faced by the frail elderly?
KEY QUESTION	What obstacles in the organization of health care do you think exist to participation in treatment decision making by the frail elderly?
FINAL QUESTION	Is there anything else that anyone feels we should have talked about?
	Summarising and verification.

Table 3 Physicians' estimation of different barriers affecting participation in medical decision making

To what proportion of your frail elderly patients do the following statements apply? (N = 29)	
Perceive to be too ill to participate in medical decision making:	No of Doctors (%)
0–20%	15 (52%)
21–40%	10 (34%)
41–60%	4 (14%)
61–80%	-
81–100%	-
Perceive different treatment strategies between different doctors:	
0–20%	5 (17%)
21–40%	12 (41%)
41–60%	5 (17%)
61–80%	6 (21%)
81–100%	1 (3%)
Perceive to have too short in-care time to participate in medical decision making:	
0–20%	1 (3%)
21–40%	5 (17%)
41–60%	5 (17%)

61–80%	10 (34%)
81–100%	8 (28%)
Perceive to have difficulties in understanding the medical information you give them:	
0–20%	-
21–40%	6 (21%)
41–60%	10 (34%)
61–80%	9 (31%)
81–100%	3 (10%)

Table 4: Physicians' thoughts on elderly patients with multimorbidity

Lacking in time	
Being challenged	Being a small part of the health care machinery
<ul style="list-style-type: none"> ➤ Having a feeling of incompetence ➤ Having to take relatives into consideration ➤ Having to take cognitive decline into account 	<ul style="list-style-type: none"> ➤ At the mercy of routines <ul style="list-style-type: none"> ○ Unfit premises ○ Indirect communication ○ Lack of continuity ○ Lack of beds ➤ Inadequate remuneration for elderly with multimorbidity