Determinants of Patient Participation for Safer Care: A Qualitative Study of Physicians’ Experiences and Perceptions

Kristina Schildmeijer1*, Per Nilsen2, Carin Ericsson3, Anders Broström4 and Janna Skagerström3,5

1Department of Health and Caring Sciences, Linnaeus University, Kalmar, Sweden
2Department of Medical and Health Sciences, Linköping University, Linköping, Sweden
3Cardiology and Specialty Medicine Centre, University Hospital in Linköping, Region Östergötland, Sweden
4Department of Nursing, School of Health and Welfare, Jönköping University, Jönköping, Sweden
5Research and Development Unit, Östergötland, Linköping, Sweden

*Corresponding author: Schildmeijer K, Department of Health and Caring Sciences, Linnaeus University, Stagneliusgatan 14, SE-391 82 Kalmar, Sweden, Tel: +46 480 696 92; Fax: +46 480 510 35; E-mail: kristina.schildmeijer@lnu.se

Received date: February 21, 2018; Accepted date: February 24, 2018; Published date: March 3, 2018

Copyright: © 2018 Schildmeijer K, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

There is a paucity of research on physicians’ perspectives on involving patients to achieve safer care. This study aims to explore determinants of patient participation for safer care according to physicians in Swedish health care. We used a deductive descriptive design applying qualitative content analysis based on the COM-B (Capability-Opportunity-Motivation-Behaviour) framework. Semi-structured interviews were conducted with 13 physicians in different types of health care units to achieve a heterogeneous sample. Based on the physicians’ accounts, we identified 15 determinants functioning as barriers and/or facilitators to patient participation for safer care. There were five types of determinants: physicians’ capability to involve patients in their care; patients’ capability to become involved in their care, as perceived by the physicians; physicians’ opportunity to achieve patient participation in their care; physicians’ motivation to involve patients in their care; and patients’ motivation to become involved in their care, as perceived by the physicians. There are many barriers to patient participation to achieve safer care. Although there are also facilitators, they tend to depend on initiatives of individual physicians and patients because organizational-level support may be lacking. Many of the determinants are interdependent, with physicians’ perceived time constraints influencing other barriers.

Keywords: Physicians; Patient participation; Patient safety; Determinants; Facilitators; Barriers

Introduction

Patient participation to achieve increased patient safety has become an area of increasing interest in policymaking, research and health care management, and practice. Patient participation can refer to patients’ participation in the decision-making process regarding various health issues, but the concept is usually understood in broader terms as patients participating in “many and varied aspects” of health care [1]. Patients are uniquely placed to observe their care and physical environment throughout their journey in the health care system [2]. Patient participation has been shown to improve decision making and treatment of chronic diseases, e.g., educational interventions for self-management and prompts given to patients to perform specific tasks [1]. It is reasonable to believe that it could also help prevent errors, although there is not much research to support this conclusion.

Findings concerning patients’ willingness and ability to participate in their own care are somewhat inconsistent. Research has shown that patients are not always prepared to commit time and energy to improve their care because they have enough to worry about when they are ill [3,4]. For many patients, physicians and other health professionals represent traditional medical authority and questioning them is an unacceptable extension of the patient’s role [4]. Studies show that patients may be apprehensive about reporting problems within their care when they interpret practitioners’ responses as unappreciative or when the patients believe that their feedback may jeopardize the practitioners’ goodwill towards the patient [1,3].

Physicians can potentially play an important role in engaging patients to achieve safer care by exchanging information, building a good interpersonal relationship and sharing decision making [5-7]. However, there is a lack of empirical research on how or the extent to which this potential is realized. We have identified only two studies that have addressed physicians’ perspectives on patient involvement for safer care; both studies used hypothetical hand hygiene and medication error scenarios. Schwappach et al. [8], conducted a study in Switzerland involving 1141 health care professionals (15% physicians). They found that the professionals in general approved of the patient intervening, e.g., reminding professionals to wash their hands, even if they believed this could have negative effects on the physician–patient relationship. A study was carried out by Davis et al. [9], in the UK involving 216 health care professionals (54% physicians). They found that the professionals perceived patients who asked about a potential error less favourably if the patient’s behaviour was considered confrontational in nature than if an enquiry was polite.

Despite increased attention to patient participation in health care, there is a paucity of research on physicians’ perspectives on involving patients to achieve safer care. In response to this knowledge gap, this study aims to explore determinants of patient participation for safer care according to physicians in Swedish health care. Improved understanding of the factors that influence how physicians can involve patients in their care is important for physicians and other health professionals.
professionals, patients, decision makers and policy makers to achieve improved patient safety.

Methods

Study setting

The study was carried out in Sweden. Health care in Sweden is mainly publicly funded although private health care also exists. All residents are insured by the state, with equal access for the entire population. Out-of-pocket fees are low and regulated by law. The provision of health care services in Sweden is primarily the responsibility of the 21 county councils throughout Sweden. The health care system is financed mainly through taxes levied by county councils and municipalities.

Study design and participants

We used a deductive descriptive design with qualitative content analysis based on a framework called Capability-Opportunity-Motivation-Behaviour (COM-B) [10], described below.

Thirteen semi-structured interviews with physicians were conducted. We used a purposeful sampling strategy to achieve a heterogeneous sample of physicians working in different health care units, with patients varying in terms of general health status (from patients seen in primary health care to inpatients in hospital care), health condition (from acute to chronic diseases and illnesses) and duration of health care contact (from outpatients to inpatients). The aim was to achieve a sample of physicians that represented a broad spectrum of experiences and perceptions concerning patient participation in relation to patient safety.

The physicians were employed in several different health care units, all located in cities (with 67,000, 135,000 and 150,000 inhabitants) in south-east Sweden (Table 1): A pulmonary ward in a university hospital (540 beds); a surgery unit in a mid-sized hospital (350 beds); an ear, nose and throat unit in a mid-sized hospital (500 beds); a rheumatology department in a university hospital (540 beds); and two primary health care centres.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Sex</th>
<th>Physicians (N=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>7 (53.8)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6 (46.2)</td>
</tr>
<tr>
<td><strong>Years of practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–1 years</td>
<td>1 (7.7)</td>
<td></td>
</tr>
<tr>
<td>2–4 years</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>5–9 years</td>
<td>1 (7.7)</td>
<td></td>
</tr>
<tr>
<td>10–20 years</td>
<td>7 (53.8)</td>
<td></td>
</tr>
<tr>
<td>21 years or more</td>
<td>4 (30.8)</td>
<td></td>
</tr>
<tr>
<td>Median years of practice (range)</td>
<td>16 (1-38)</td>
<td></td>
</tr>
</tbody>
</table>

| **Years in the health care facility** |     |                   |
| 0–1 years | 2 (15.4) |

Table 1: Participant characteristics (Values are number (%) except where indicated).

The physicians were recruited via an e-mail that briefly described the study. The e-mail request was sent to the director of each health care facility, who in turn asked the physicians to participate in the interviews. All respondents provided informed consent and agreed to participate in the study.

Data collection

An interview guide with qualitative semi-structured questions was used for the data collection [11]. The questions were generated by the research team with reference to the existing literature on patient participation for safer care.

The questions were tested in one pilot interview with regard to meaningfulness for participants and clarity of concepts. The pilot interview indicated that the wording was clear and that the interview did not exceed 45 minutes (deemed feasible with regard to the participants' busy work schedule).

The interview guide dealt with issues concerning the physicians' experiences and perceptions regarding patient participation relevant to patient safety. There were general questions on how patients can influence patient safety, as well as more specific questions concerning their own experiences and examples of patients who have observed something of importance for patient safety. The interview guide ended with questions on existing routines and tools to account for patients' views, experiences and suggestions on how patient participation to reduce errors in health care can be achieved.

During the interviews, the interviewer asked probing questions, e.g. “Can you explain a little further?” Towards the ends of the interviews, the interviewer asked if there was more to discuss or if something needed further clarification. All interviews were recorded and transcribed verbatim.

The interviews took place between June 2015 and June 2016 and were conducted, recorded and transcribed by K.S., C.E. and J.S., all of whom are experienced in different interview techniques. No extra compensation was given to the physicians because the interviews were held during regular working hours at the health care units where the participants worked. No physician had a relationship with any of the researchers. The interviews lasted between 18 and 40 min.
Theoretical framework

We applied the COM-B framework developed by [10] Michie et al. to categorize the barriers and facilitators (i.e. determinants) to patient participation of potential relevance to patient safety. Barriers were defined as physicians’ and patients’ actions, beliefs and attitudes that made patient participation for safer care more difficult, whereas facilitators were defined as physicians’ and patients’ actions, beliefs and attitudes that made patient participation in safer care easier. Some determinants could function as both barriers and facilitators.

COM-B sets out that behaviour, e.g. a physician’s communication with a patient, comes about from an interaction between the capability to perform the behaviour and the opportunity and motivation to carry out the behaviour. The framework is intended to be comprehensive, parsimonious and applicable to all behaviours. Earlier studies have applied COM-B to many different types of behaviours, including patients’ medication adherence [12], audiologists’ behavioural planning [13] and health coaching for women with diabetes [14].

Capability is defined as an individual’s psychological and physical capacity to engage in the behaviour. It includes having the necessary knowledge, ability and skills. Opportunity is defined as all the factors that lie outside the individuals that make the behaviour possible or prompt it, e.g. the physical environment and the social and cultural context. Motivation or willingness to enact behaviour is defined as all those brain processes that energize and direct individuals’ behaviour, including habitual processes, emotional responding, as well as analytical decision making [10].

Data analysis

The interview data were analysed using directed content analysis in accordance with Hsieh and Shannon [15]. A directed approach was deemed applicable because we wanted to analyse determinants of patient participation for safer care, as perceived by the physicians who were interviewed, in light of an existing framework, i.e. COM-B.

As a first step, all the authors read all transcripts to obtain an understanding of the whole. The transcripts were then coded separately by two of the authors, K.S. and P.N., using a directed content analysis that included a structured analysis process to code and categorize the data using COM-B. Hence, COM-B was used to determine the coding and relationships between the codes. Data that could not be coded or identified in relation to the framework in the first step were analysed later to determine if the data represented a new category or a subcategory of an existing category [15].

In the next stage, K.S. and P.N. discussed the interpretation of the data in relation to COM-B and compared their coding. They then presented their categories (i.e. capability, opportunity and motivation) and their contents to the other researchers. Discussions in the group continued until no inconsistencies existed and a shared understanding was reached to increase trustworthiness and strengthen the internal validity [16]. Representative quotations were identified to report the findings. Quotations were then translated from Swedish to English by P.N. and K.S., both of whom are familiar with English. The physicians are numbered 1 to 13 in the Results section.

Ethical considerations

The study was performed according to the World Medical Association Declaration of Helsinki ethical principles for medical research involving human subjects. All the participants gave their consent to participate in the interviews. The study did not require ethical approval because it did not involve sensitive personal information, as specified in Swedish law regulating ethical approval for research concerning humans [17].

Results

Analysis of the data yielded 15 determinants (i.e. subcategories), functioning as barriers (B) and/or facilitators (F) to patient participation of potential relevance for patient safety, according to statements by the physicians (Table 2). These 15 determinants were mapped to five types of determinants (i.e. categories) of patient participation that could contribute to improved patient safety: physicians’ capability to involve patients in their care (C in COM-B); patients’ capability to become involved in their care, as perceived by the physicians (C); physicians’ opportunity to achieve patient participation in their care (O); physicians’ motivation to involve patients in their care (M); and patients’ motivation to become involved in their care, as perceived by the physicians (M).

<table>
<thead>
<tr>
<th>Category in the COM-B framework</th>
<th>Type of determinant (categories)</th>
<th>Determinants (subcategories)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability</td>
<td>Physicians’ capability to involve patients</td>
<td>Relationship with the patient (B+F)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication with the patient (B+F)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attention to the patient (B)</td>
</tr>
<tr>
<td>Capability</td>
<td>Patients’ capability to become involved</td>
<td>Patients’ physical and mental status (B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients’ knowledge and understanding (B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients’ reactions to the situation (B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients’ language proficiency (B)</td>
</tr>
<tr>
<td>Opportunity</td>
<td>Opportunity to achieve patient participation</td>
<td>Time (B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity of care (B+F)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routines and tools (B+F)</td>
</tr>
</tbody>
</table>
Physicians’ capability to involve patients in their care

**Relationship with the patient (B+F):** Physicians’ capability to interact with patients constituted a determinant of patient participation of potential relevance to patient safety. Failure to establish such a relationship could result in missed opportunities to capture safety hazards related to the patient’s treatment or care that the patient may detect. On the other hand, physicians also described how a satisfactory relationship could facilitate patient participation. “The most important thing is that you [the patient] can be open and say what’s in your heart, and that requires a relationship that makes it possible to do this” [9].

**Communication with the patient (B+F):** Physicians’ communication with the patient, including various forms of information, was another determinant of patient participation. Examples included physicians asking patients for confirmation of understanding the information provided and repeating important information. “If you [the patient] have good information, there are many things you won’t need to discuss or ask about because it has already been clarified” [11].

Physicians also described instances where communication could function as a barrier to patient participation. According to physicians, communication that is too standardized and not sufficiently adapted to each patient’s unique understanding or capacity could lead to missed opportunities to identify safety hazards via the patient. “If you talk about patient safety and the patient’s own involvement, it’s important that the patient is ‘with you’ all the way, that you work from this patient’s existing knowledge, capacity, wishes and desires. And we don’t individualize information that way” [1].

**Attention to the patient (B):** Further, physicians stated that insufficient attention, e.g., due to meeting or treating large numbers of patients, could cause them to overlook safety hazards that the patient may hint at or bring up in conversation. “You do it [surgical operations] many times, and the focus tends to wander so you don’t really notice things; you get a bit speed-blinded” [5].

**Patients’ capability to become involved in their care, according to the physicians**

**Patients’ physical and mental health status (B):** Physicians mentioned that patients’ physical or mental illnesses or limitations could restrain their ability to become involved in their own care. “There are also patients who cannot make their voice heard or who are intellectually disabled so they do not intellectually grasp why they’re controlled, and that means bigger risks” [12].

Physicians’ expressed that issues with patients having limited understanding to detect errors and safety hazards with regard to various aspects of their treatment, care or health care environment constituted a barrier to patient participation. Physicians argued that many patients simply are not sufficiently cognizant concerning their illness or care to be able to make meaningful contributions to safer care. One physician remarked that “the best thing the patient can do to achieve patient safety is to train to become both a doctor and a nurse” [6]; another opined that patients are “at the mercy of a profession” [8] because they have insufficient knowledge and understanding.

**Patients’ reactions to the situation (B):** Physicians further contended that patient participation could depend on how patients reacted to the situation they were in. Patients who are unaccustomed to the health care environment may experience a sort of sensory “overload” because they receive information from many sources and meet with numerous practitioners. These circumstances might make it difficult to be potentially active in one’s own treatment or care, thus acting as a barrier to patient participation, especially for those patients who have multiple illnesses. “There are many things going on at once, several illnesses, several different health care providers, and many medications. A lot of information, to sort out and combine” [10].

**Patients’ language proficiency (B):** Language difficulties could hinder patient participation for safer care, according to the physicians. “There can be a language barrier. Sometimes they [the patients] don’t understand the symptoms; they don’t understand. Well, then it [information] can fall between the cracks and something will go wrong” [1].

**Physicians’ opportunity to achieve patient participation for safer care**

**Time (B):** The physicians frequently brought up time constraints as a barrier to patient participation of potential relevance to patient safety. They recognized that shortage of time with their patients makes it difficult to establish trustful relationships with the patients and account for all questions and concerns a patient might have. “We don’t always have the time to give the patient the attention he believes he should have or thinks he deserves” [6]. Shortage of time can lead to stress. “It’s a question of time. Patients can have a lot of opinions, and there can be many opinions that are valuable, but there are also opinions that you do not feel you have the possibility or time to take care of, at the moment. And then this stress factor enters, which is a big safety hazard in health care” [1]. Physicians also noted that their time with patients was not always spent wisely. “Sometimes we go into discussions about things that aren’t so relevant. That’s not good for the patient, as the
focus turns to something that might not be so important, and it takes a lot of time” [8].

**Continuity of care (B+F):** Physician continuity influenced the opportunity to achieve patient participation. “In many places you might meet a new health care provider every time, someone who is a stranger, and I believe continuity facilitates the possibility to criticize” [9]. Whereas lack of or poor continuity constituted a barrier, physicians believed that good continuity could act as a facilitator because it could positively affect the relationship with patients. “I think it would make it easier if we had better continuity in health care, so you met the same person every time. It would make it easier to convey both positive and negative critique” [10].

**Routines and tools (B+F):** Routines and tools to provide support or more hands-on guidance for achieving patient participation constituted another determinant of involving patients. Physicians commented on the lack of recommendations concerning how to involve patients in their care as a barrier. “There is nothing standardized that tells you that you should ask the patients what they have understood of this” [1]. In general, the physicians did not identify any existing routines or tools that facilitated patient participation. However, they described numerous activities that involved patient participation to some degree, e.g. a national patient survey questionnaire and various forms of adverse events reporting. They had ideas for further tools to achieve improved patient participation of potential relevance to patient safety, including providing new patients with an introductory leaflet encouraging them to voice their opinions and ask questions, provision of a brief patient questionnaire directly related to delivery of care, a discharge dialogue to account for patient complaints and concerns, and some form of “talk-back” technique to make sure the patient has understood and processed all the information.

**Physicians' motivation to involve patients in their care**

**Initiating patient engagement (B+F):** Physicians noted the challenges of initiating patient engagement, which appeared to function as a barrier or facilitator depending on the physicians' actions. They recognized the importance of actively inviting the patient to communicate; one physician noted that “if you're not invited to the conversation, it's difficult” [1]. However, physicians with previous experience of patients who never seemed to be content expressed reluctant feelings to actively engaging patients. "Sometimes you think when a patient has started asking a lot of questions and they have received many replies, that they should be satisfied” [6].

**Learning from patients who detect errors and safety hazards (B+F):** Physicians expressed ambivalence about patients who detected slips or mistakes in their clinical practice. Learning from such patients seemed to function as a barrier or facilitator to patient participation depending on the individual physician. One physician argued that “it has to do with your personality and how well you can handle criticism” [7]. Another physician observed that it’s possible that some [physicians] think it's interference in their professionalism or that they [patients] step over some sort of boundary that makes them feel attacked” [1]. The physicians were not entirely comfortable with patients who pointed out errors or safety hazards that they were unaware of. "It can be embarrassing, humiliating, if you recognize you have made a mistake” [2]. At the same time, physicians also expressed sentiments of gratitude to inquisitive patients. Physicians mentioned that patients who asked many questions could make them think twice. "If it’s me who has made the mistake, it may feel awkward, so, but it's great that they say it” [6]. They also said that there were situations when the patients knew things about their medication or health that were unknown to the physicians. Some physicians stated that they were relieved that patients had observed errors and hazards before something undesirable occurred.

**Patients' motivation to become involved in their care, according to the physicians**

**Patients' perceptions of physician authority (B):** Physicians recognized patients’ reluctance to question physicians’ authority as a barrier to patient participation. They argued that this hesitancy could lead to patients refraining from asking pertinent questions or commenting on circumstances to prevent errors. “The patient is usually in some kind of subservient position. The doctor has a certain authority and you don't dare to question. They [the patients] are also at a knowledge deficit” [10].

**Patients' communication of sensitive information (B):** Physicians said that safety hazards may go undetected when patients are unwilling to communicate information that the patient may consider to be sensitive. “There might be things you [the patient] are ashamed of saying, which you think are not important. You might worry that mentioning this might have undesirable consequences” [10].

**Patients' socio-demographic characteristics (B+F):** Physicians also commented that patients’ motivation to participate was associated with various socio-demographic characteristics, such as age, level of education and social and cultural background. There appeared to be few consistent patterns with regard to how the various characteristics affected patient participation. Older age was an exception; it was viewed by many physicians as a barrier to patients’ motivation to participate in their care. Some physicians commented that younger patients tend to be more inquisitive than older patients, thus being a facilitator for patient participation. “The younger generation is quite different. I mean, they are demanding in a different way” [2].

**Discussion**

This study explored determinants of patient participation to achieve safer care, as perceived by physicians in Swedish health care. Based on the physicians’ accounts, we identified 15 determinants (barriers and/or facilitators). These were mapped onto the COM-B framework [10]. We found the structure and content of COM-B to be relevant for the study, offering a plausible theoretical explanation of determinants of patient participation of potential relevance for patient safety and providing a useful tool to categorize facilitators and barriers. We did not identify any determinants that did not fit into the framework. Eight of the determinants functioned solely as barriers to patient participation and seven could act as barriers or facilitators, depending on the individual physicians and patients involved.

The physicians believed that patients’ motivation to be involved in their own treatment and care was constrained by the patients’ impression of being subordinate to physicians, whom they recognized as an authority that they were reluctant to question or criticize. The physicians seemed very much aware of patients’ respectful views of them. Our findings are consistent with previous research conducted from the point of view of patients, which found that patients believe it is inappropriate to challenge health professionals in general [18,19], are fearful of questioning medical authority [20,21] and are afraid of offending physicians [22-25]. It has been shown that patients consider that physicians hold an elite position in health care; thus they are more
willing to ask challenging safety-related questions of nurses and more likely to ask physicians factual questions related to quality and safety [23].

The time-pressed everyday clinical practice of most physicians in this study presented a barrier to patient participation for safer care. Again, this finding is very much consistent with previous research, which has found that a busy clinic setting inhibits patients' involvement in their treatment and care [26-28]. Many changes in clinical practice have led to increased demands on physicians to document various aspects of their work, which has often been attributed as a key reason for reduced time with patients [29-31].

The physicians believed that time pressure made it more difficult for them to maintain full focus and attention on the patient, achieve well-functioning communication and establish a trusting relationship with the patient, implying interdependency between many of the determinants identified in this study. Time with the patient matters; longer visits to physicians are associated with increased patient centredness, more attention to psycho-social problems, lower prescribing rates, better-quality prescribing and lower return consultation rates [32,33]. The importance of a strong relationship between the patient and health professional for patient participation has been demonstrated in previous research from the patient's perspective [34-37]. Patients' motivation to participate in their own treatment and care is reduced when patients have concerns about being ignored, dismissed, not believed or not taken seriously [20,21,27,36,38]. A poor relationship compromises communication because patients may limit the information they share with health professionals who they distrust or feel uncomfortable with [39].

The physicians further believed that patient participation for safer care might be negatively affected by patients' unfamiliarity with the health care environment and a somewhat limited understanding of their own treatment and care. Research has shown that patients have difficulties understanding medical terminology [25] and have insufficient knowledge about their own treatment and care [37]. Access to information has been found to be positively associated with patients' willingness and ability to become involved in their own treatment and care [28,40,41]. Information can improve self-efficacy and risk perception, which increases the likelihood that patients can detect and speak up about errors and safety hazards [25].

Difficulties associated with some patients' physical and mental health status constituted another barrier to patient participation in our study. Findings from several studies conducted from the patients' perspective suggest that willingness and ability to be involved in one's own treatment and care tends to be inversely proportional to the severity of the patient's disease [42-45]. Patients are in a vulnerable situation and put themselves under the control of health professionals because they have no choice [4]. Poor language skills also acted as a barrier to patient participation in our study, consistent with previous research, which has emphasized the importance of the ability to communicate well with health professionals to enable patient participation [25,36,37,46,47].

Physicians' motivation to initiate patient engagement could act as both a barrier and a facilitator. The physicians recognized the importance of actively inviting the patient to participate. Other studies have shown that more active engagement by patients is facilitated by encouraging or instructing them to ask questions or to participate in specific actions [23,27,48]. However, some physicians in our study expressed hesitancy about encouraging patients to ask questions because they saw a risk in entering into time-consuming discussions about less important matters or discussing with patients who were never content with the replies they received. Physicians have been found to avoid discussions of certain aspects of patients' problems if they believe they cannot handle the issues well or believe they have insufficient time to do so adequately [49,50].

Learning from patients who identified errors or hazards was also associated with some uncertainty on the part of the physicians. Although they recognized the relevance to patient safety of patients who detected errors and safety hazards, the physicians also admitted to feelings of guilt and embarrassment when they realized that they had made slips or mistakes that could have caused patient injuries. Physicians have been described as the "second victim" of medical errors because they can experience emotions related to sadness, fear, anger and shame when they are involved in medical error [6,39,51-53]. The findings regarding physicians' ambivalent feelings towards patient participation are not echoed in other studies on this topic. However, this may be explained by the fact that most of the research thus far has been conducted from the viewpoint of patients, who may not always recognize physicians' uneasiness about some aspects of patient participation.

Although the physicians described the importance of organizational-level routines, such as adverse event reporting, they could not point to any specific routines or tools for use in their actual meetings with patients to facilitate patient participation. These findings imply that patient participation for safer care is largely left up to the individual physician and is dependent on his or her ability and willingness to involve patients in their treatment and care. Furthermore, many of the determinants that acted as both barriers and facilitators in our study depended on individual physicians' capability to communicate well and establish good relationships with their patients and the physicians' motivation to initiate patient engagement and learn from patients who detect errors and safety hazards, which has also been found by others [23,27,48,49]. The dependency on the individual physician seems counterproductive to achieving more systematic patient participation of relevance to patient safety. It also contrasts with the systems perspective on patient safety widely advocated today [53], calling into question the extent to which patient participation can contribute to attaining safer care.

This study has a number of shortcomings that must be considered when interpreting the results. The sample size was relatively small although the data analysis confirmed that data saturation was reached before cessation of the interviews. The voluntary nature of participation in the study means that the physicians interviewed may differ from the broader population of physicians. These physicians were recommended by the managers of the health care facilities we approached, suggesting that they could be biased towards being more interested in patient participation and/or patient safety issues. The results should not be generalized to a larger population of physicians (i.e. statistical generalization). Instead, we sought analytical generalization by comparing our findings with other studies on patient participation (although most previous research was conducted from the patients' perspective).

Conclusion
There are many barriers to patient participation to achieve safer care. Although there are also facilitators, they tend to depend on the initiatives of individual physicians and patients because
organizational-level support may be lacking. Many of the determinants are interdependent, with physicians’ perceived time constraints influencing other barriers. Patient participation depends on physicians’ capability to achieve favourable physician–patient communication and a strong relationship with the patient. Their motivation to involve patients by initiating patient engagement and learning from patients who detect errors and safety hazards is important for achieving patient participation.

Acknowledgements

Many thanks to the physicians who participated in the interviews.

References


