Management of Newly Diagnosed Atrial Fibrillation in an Outpatient Clinic Setting - Patient’s perspectives and experiences

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None to declare

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ABSTRACT

Aims: To gain in-depth knowledge of patients’ experiences of the consultation processes at a multidisciplinary atrial fibrillation outpatient clinic in a university hospital in Denmark.

Background: Atrial fibrillation is the most common cardiac arrhythmia associated with morbidity and mortality if not diagnosed and treated as recommended. Patients with newly diagnosed atrial fibrillation preferably should be managed in an outpatient setting which includes medical examination, patient education and decision making on medical therapy.

Design: This is a qualitative study of 14 patients newly diagnosed with atrial fibrillation, ranging from asymptomatic patients, to those with mild to severe symptoms; they were all referred from general practitioners.

Methods: Data was generated in 2013-2015 using participant observation during each consultation, followed by individual interviews post-consultation.

Results: Patients were referred with limited information on AF and knowledge about the management consultation procedures. The consultations were performed in a professional way by the cardiologist as well as by the nurses with an emphasis on the medical aspects of atrial fibrillation. The understanding that atrial fibrillation is not a fatal disease in itself was very important for patients. At the same time, visiting the
Conclusion was overwhelming, information was difficult to understand, and patients found it difficult to be involved in decision-making.

Conclusions: This study indicates that patients were uncertain on what AF was before as well as after their consultation. The communication was concentrated on the medical aspects of atrial fibrillation and visiting the clinic was an overwhelming experience for the patients. They had difficulty understanding what atrial fibrillation was, why they were treated with anticoagulation, and that anticoagulating was a lifelong treatment.

Relevance for clinical practice: This study demonstrates some lack of patient-centred care and an absence of tailored patient AF-related education. Furthermore, the study highlights the need for and importance of active patient involvement.

Keywords: atrial fibrillation, clinical management, multidisciplinary care, outpatient clinic, patient experiences.

Summary box

What does this paper contribute to the wider global clinical community?

- This study included patients newly diagnosed with atrial fibrillation referred from general practitioner to an outpatient AF-clinic. The results signify a lack of patient-centred care and an absent of tailored patient AF-related education.
- There is a need of more active patient involvement in shared decision making taking patient beliefs and knowledge in consideration.
- In the content of changes in global health care services more information on how outpatient clinic is managed is required.
BACKGROUND

Atrial Fibrillation (AF) is the most common cardiac arrhythmia and is associated with increased morbidity and mortality (Camm et al. 2010). It is estimated that the incidence of AF will at least double by the year 2050 (Broge 2011, Naccarelli et al. 2009, Rich 2009, Stewart et al. 2004) reaching epidemic levels (Chugh et al. 2014) and complications will expand dramatically. Poor guideline adherence in the management of AF (Estes et al. 2011) will influence the patients’ AF symptom burden (Bohnen et al. 2011) and increase the economic burden of the health care system (Ringborg et al. 2008, Savelieva & Camm 2008, Stewart et al. 2004).

There is a wide variety in the way patients experience AF symptoms ranging from completely asymptomatic patients to those with a complex burden of severe physical symptoms, and related mental and social consequences (Camm et al. 2010, Deaton et al. 2003, Kellen 2004) which are associated with increased uncertainty, resulting in poor mental and general health (Kang 2005). AF symptoms include palpitations, shortness of breath, fatigue, dizziness, and syncope (January et al. 2014).

Symptoms can be misinterpreted by patients as well as by health care providers as not being disease-related and being caused by other conditions such as ageing, physical deconditioning or stress, resulting in delay of diagnosis and treatment (McCabe et al. 2014).

Patients with AF have also been found to have a significantly lower Health-related Quality of Life (HRQOL) and more symptoms of anxiety and depression compared to the general population and to patients with other heart diseases (Thrall et al. 2006, Thrall et al. 2007). This might be caused by delayed diagnosis, lack of caring support to cope with the emotional burden of AF, distress caused by unpredictable AF symptoms and lack of counselling regarding the nature of AF and self-management.
(McCabe et al. 2011). AF accounts for one third of all hospital admissions for arrhythmia (Fuster et al. 2006), which is the primary cost driver in AF management (Reynolds et al. 2007) in North America as well as in Europe (Chugh et al. 2001, Tsang et al. 2003). Furthermore, Reynolds et al. (Reynolds et al. 2010) compared symptom frequency and HRQOL between hospitalised AF patients versus non-hospitalised. They found that increased symptom frequency and severity as well as reduction in HRQOL were associated with hospitalisation.

An intervention to contribute to reducing hospitalisation significantly in these patients is to strengthen outpatient services for elective treatment and short-term follow-up (Conti et al. 2012). A nurse-coordinated outpatient clinic might contribute to this in terms of reducing waiting times and number of appointments, improving patients’ experiences of arrhythmia services, and reducing healthcare costs (Wise & Annus 2013). Furthermore, a Dutch study demonstrated that a nurse-coordinated AF-clinic had a positive impact on guideline adherence (Hendriks et al. 2010). This effect is also shown in a subsequent study comparing a nurse-led AF-clinic with usual care (Hendriks et al. 2012). In this study, Hendriks et al. demonstrated that a nurse-led AF-clinic, improved patient management, and clinical outcomes in terms of reduced cardiovascular hospitalisations and death while being a cost-effective management approach (Hendriks & Strömberg 2015).

Little is known from the literature about how patients with newly diagnosed AF are informed about AF and its treatment options in an outpatient clinic setting and what patients’ attitudes and beliefs are towards participation in treatment decisions. Thus, the purpose of this study was to describe newly referred AF patients’ experiences of the consultation processes at an AF-clinic.
METHODS

This is a qualitative study with a descriptive design following an ethnographic approach which is appropriate for studying processes and relationships among people and events during time (Jorgensen 1989). The researcher observed the consultations by following the patients in the AF-clinic and through this, the researcher gained insight in what took place before as well as during and after the consultations. The researcher made fieldnotes (Spradley 1980) on who was involved and how they reacted, when and where activities happened and how activities influenced the patients (Jorgensen 1989). Furthermore, semi-structured individual interviews (Kvale 2007, Körner 2010) with patients were performed after consultations were ended by the researcher.

Study participants

Participants were recruited between 2013 – 2015 and were eligible for the study if AF was documented on ECG, they were referred from a GP practice for the first time due to newly diagnosed AF, were aged 18 years or older, and were able to understand and speak Danish. Patients were recruited prior to their first consultation in the outpatient clinic. Patients were excluded if they had any comorbidity which was unsatisfactorily treated, if they had a pacemaker implanted three months prior consultation, or if they were discharged after the first visit in the AF-clinic.

Setting

The study took place in an AF outpatient clinic at a large university hospital in Denmark. The multidisciplinary team (Fridlund et al. 2015, Körner 2010) at this clinic consisted of a cardiologist who was a specialist in heart rhythm diseases (HRS) and
two AF-specialized nurses, who had a wealth of experience in AF and had worked with AF-patients for several years. The nurses and the cardiologist formed the AF treatment team, each with specific tasks and responsibilities. The organisation of care in the AF-clinic was as follows: the patients’ first appointment was with the cardiologist, who performed physical and medical examinations (ECG, echocardiography and medical history), questioned the patients about their signs and symptoms, informed the patients about AF and initiated medical treatment. At follow-up consultations, patients were seen by the specialized AF nurse. During consultations, the nurse had more time to talk with the patients, focusing on ECG control, burden of AF-symptoms, the patients’ response to treatment and how patients were handling their symptoms and treatment. The nurse explained medications, and changed medical treatment, if necessary, after consultation with the cardiologist. The nurse coordinated the care, decided for how long patients were followed in the AF-clinic and when patients were discharged to follow-up by their GP. If the patient had more than one consultation with a nurse, patients did not always see the same nurse as previously. Each consultation took approximately 30 to 45 minutes.

**Data collection**

Data was collected in three ways: by following patients pre-consultation in the waiting area; during every consultation at the AF-clinic; and by semi-structured individual interviews post-consultations. The researcher followed each patient during every consultation in the clinic from arrival to leaving the hospital after consultation (table 1). Fieldnotes, i.e. in terms of condensed notes (Spradley 1980), were taken during the event. The following variables were recorded: time of patient arrival at the waiting area; time when
consultation started; time for procedures and activities (i.e. echocardiography, ECG, information about AF and treatment) during consultation; and time when consultation ended.

Fieldnotes were taking in the waiting area before each consultation regarding the patients’ expectations on the consultation and thoughts about his / her illness. During each consultation (N= 42), the researcher passively observed and took fieldnotes on how related activities were performed, on how the patient was placed in the room, how the patient and the cardiologist / nurse reacted to each other, and how verbal as well as nonverbal communication proceeded between the patient and the cardiologist or the nurse. After the consultation, the researcher questioned the patients on their experiences during the consultations. Afterwards, the condensed notes were expanded with missing information, as recommended in the literature (Spradley 1980).

At the final follow-up of consultation in the AF-clinic, a semi-structured digitally recorded interview (Kvale 2007) took place in a quiet room at the hospital or in the home of the patient. The interview focussed on patients’ experiences of consultations in the AF-clinic and how it affected their way of handling AF. Data collection was performed by the first author, who was not involved in the delivery of care to patients that participated in the study.

Analysis

The transcribed fieldnotes and interviews appeared as text which were analysed and interpreted in a phenomenological-hermeneutical approach based on Paul Ricoeur’s interpretation theory (Ricoeur 1976). The analysis took place in a back and forth process between understanding and explanation of the meaning of the text. The
analysis was carried out in three analytical steps: 1) naïve reading, 2) structural analysis and 3) critical interpretation and discussion. Thus, the text was opened up for a possible understanding of what the meaning in the transcribed interviews and fieldnotes referred to in the consultation situation (Ricoeur 1973).

Naïve reading is the first conjecture of the analysis (Dreyer & Pedersen 2009, Ricoeur 1976). The transcribed fieldnotes and interviews were read several times in a non-judgemental way in order to grasp the meaning of the text as a whole. What did the text say at first glance about how participants experienced the consultation processes and how they handled their illness?

Structural analysis intends to clarify the dialectics between the naïve reading and the interpretation of what the text is about, moving from units of meaning (what the text is saying) to units of significance (what is the content of the text) (Dreyer & Pedersen 2009). An example of how the main theme, “Visiting the clinic – an overwhelming experience”, emerged is illustrated in table 2.

The transcribed fieldnotes and interviews were read and reread, and parts of the text were enhanced when there was a reference to how the consultations progressed, how interactions with health care professionals proceeded and were experienced, and how thoughts of illness were expressed. In this analytic step, main themes and subthemes related to the purpose of the study were generated.

Results of the structured analysis were subsequently critically interpreted and discussed by the authors. The intention of critical interpretation and discussion was to move from an understanding of participants' experiences to a possible understanding of what their experiences referred to in the consultation processes in the AF-clinic and in the patients' thoughts of living with AF. The critical interpretation and discussion appears in the discussion section of this article where the naive
reading, the findings from fieldworks and interviews, and results from the literature review form a comprehensive understanding of the generated data.

**Ethical considerations**

The study was reported to the Danish Data Protection Agency (no. 2008-58-0035) and conducted according to the principles outlined in the Helsinki Declaration (Association 2013). All participants gave written informed consent. We applied for Ethical approval but formal approval from the local ethical committee was not required according to legislation in Denmark.

**RESULTS**

**Participants**

As illustrated in Table 1, fourteen patients (7 males and 7 females), aged between 40 years and 82 years (mean ± Standard Deviation: 68.2, ± 10.2) were consecutively included from February 2013 to September 2014. Symptoms of AF were asymptomatic (3) or patients reported mild or severe palpitations and dyspnoea. Types of AF: Paroxysmal (5), persistent (1), permanent (8); the total number of consultations with the cardiologist and the nurse ranged from 2 to 5, with an average of 3 and a total of 42 consultations were included in the study.

**Naive reading**

The overall impression of the naive reading was that although patients were very satisfied with their consultation in the AF clinic, it did not lead to a clear understanding of AF and why they had received the suggested treatment. The patients described uncertainty around what caused the AF symptoms and why they
were treated with oral anticoagulation medicine. They adhered to the prescribed treatment, but did not understand the effects of the medications. Furthermore, it was difficult for them to explain AF in their own words. The most important value of the consultations was that patients were told that they would not die from AF in itself.

Structured analysis
The results from the structured analysis of the transcribed fieldnotes and interviews indicate similarities in the results. These results were associated with certain themes and subthemes (table 3) and sequenced according to the patient journey in the AF-clinic. The themes are: “Uncertainty about atrial fibrillation before first consultation”; “Focus on the medical aspects of atrial fibrillation”; “Atrial fibrillation is not a fatal disease”; “Professionalism and competence in the care of atrial fibrillation”, and “Visiting the AF-clinic – an overwhelming experience”.

Uncertainty about atrial fibrillation before first consultation
In some patients, AF was detected by coincidence, when consulting a GP for a regular control of their diabetes or hypertension. Patients were surprised that they had a heart disease and describe the AF diagnosis as shocking. For other patients, mild or more severe symptoms had been interpreted as driven by age, poor lifestyle or lack of fitness:

FJ: “I was just sitting quietly not doing anything and then something suddenly happened. At first time I thought it was caused by smoking a pipe, because that could raise the pulse. I refrained from smoking for a week or so to see if it stopped, but nevertheless it came back. This was damned surprisingly – without any form of physical activity… And then I consulted my GP”.

Almost none of the patients received any information about AF by their GP. They were referred to the outpatient clinic because of “something with my heart rhythm”.

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Only one patient had searched for information before the first consultation in the AF-clinic.

Furthermore, patients were not informed about procedures in the AF-clinic beforehand. Therefore patients often did not discuss with their relatives how to prepare for the first visit to the AF-clinic (e.g. important questions), and they also did not know what to expect.

A patient and her husband said:

HN: “We [patient and her husband] did not know, what was going to happen during the first consultation. We expected an examination, but we did not know how that would be.”

Another patient expressed:

JT: “It was difficult to prepare not knowing what was going to happen during consultation and when consultation in the AF-clinic ended”

**Focus on the medical aspects of atrial fibrillation**

The medical examination at the first visit by the cardiologist lasted on average 35 minutes. Finally, for the last 10 to 15 minutes of the consultation, patients were given information about the AF and about the decision making process on the medical treatment they would receive.

One patient expressed his thoughts after the first consultation like this:

NH: “It was very difficult to understand and remember what was said and what was decided during the consultation. I needed to visit my GP to have more information about what it all means”

The nurses carried out their consultations in almost the same way as physicians by starting the consultation by doing an ECG and afterwards talking with the patient how they were handling the treatment, whether there were any side-effects, and how AF symptoms affected their daily life. Nurses did not ask patients about their
experiences of previous consultation and how patients reacted to having AF and being treated with anticoagulation.

Before ending each consultation, patients were asked whether they had any questions. Almost none of the patients had any questions and one patient mentioned afterwards that “It was difficult to know what I should ask for”. Questions concerning AF and treatment appeared while patients were at home and when relatives asked what had happened during the consultation.

**Atrial fibrillation is not a fatal disease**

Prior to the first consultation, severe symptoms with episodes of rapid palpitation unleashed the fear of dying and concerns on whether the heart was damaged over time or might wear out. Metaphors such as “a machine going too fast and needing oil” or “the machinery” or “tick-tick nearly stops” were used. Their situation was compared to friends and relatives who had a heart disease without knowing what kind of disease it was. A patient expressed it like this:

AH: “I had been told horrible stories and was really afraid that my heart would be damaged because of the [AF] attacks”

Recurrences had a disabling impact on their daily life and could appear when patients were resting while reading or watching TV. They did not know how to react. The patient cited below had several episodes for a longer period without consulting a GP:

KL: “It [the attack] continued during the whole night, and I did not dare to fall asleep.”

Some had an episode during exercise:

FJ: “I was playing badminton, and at the same time, I had an attack and thought: damned – now it is your turn [to die]”
The cardiologist as well as the nurses reassured the patients that they would not die because of AF in itself, and information on risk factors focussed on the risk of bleeding and how to handle this. The knowledge that their arrhythmia was not fatal was crucial and important in coping with their situation.

JT: “Knowing that I was not going to die because of AF was the most important information from the consultation. To be referred to the AF-clinic was the best thing that could happen to me”

**Professionalism and competence in the care of atrial fibrillation**

The medical examination (ECG, echocardiography and medical history taking) by the cardiologist lasted on average 35 minutes and was described as profound. The cardiologist was seen as very competent and meticulous as were the nurses in the follow-up consultations. The cardiologist and nurses handled the consultation in a confidence-building way for most of the patients, taking their situation seriously and took sufficient time for the consultations. A patient expressed it like this:

EH: “When I left the first consultation, I had a feeling that he knew a lot about this disease. But he also listened to what it did to me. And it made a big difference. I left with a feeling of how my situation was maintained or noted – that’s me”

And another patient says:

JH: “It inspired confidence to be examined by a person who was competent and did it in a meticulous way”.

The patients were being seen by the cardiologist as well as the nurses who took the time to listen to the patients, and there was no rush during consultations.

Afterwards, AF recurrences with palpitations and other AF-symptoms seem to result in less concern compared to pre-consultation.
Visiting the AF-clinic – an overwhelming experience

The medical examinations and the extensive information on AF were difficult for patients to follow and to understand. At the same time, most patients were elderly and some were using a hearing aid, and the physician was talking fast and for most of the time.

After the first consultation, some patients were confused regarding AF as a condition, the AF diagnosis, and the prescribed therapy.

FJ: “When I came home, my wife asked: Why do you get this medicine and why do you get this other medicine? I really can’t explain – it has something to do with my heart. [pause] My wife sees things as bigger problems whereas I [pause] well…. I do have a more relaxed way of handling the situation… Looking back, I would have preferred that my wife had been able to participate during the first consultation”

Before the second consultation, asymptomatic patients expressed the view that they hoped AF would be cured by treatment with anticoagulation and that they could stop taking these medications, given that they were in sinus rhythm again. Symptomatic patients hoped that the examination (e.g. ECG recording) would show a reduction of AF due to the treatment, even in the cases which were only treated with anticoagulation, and that they could reduce or terminate the medical treatment. Most patients did not understand the association between AF, anticoagulation and stroke, and the fact that AF was a lifelong disease. Some of them did not take the medicine as prescribed for various reasons, e.g. having discomfort linked solely to the medicine altogether, forgetting to take the medicine several times, and not redeeming the prescription.

Some patients received a brochure about treatment at the end of the first consultation – others did not. They did not read the brochures afterwards, and there was no follow-up on the contents in the brochures by the nurses. During the final
interview, almost none of the patients could describe in their own words what AF is and why medical treatment was prescribed. They just took the medicine without knowing any details about how it would affect their disease because the cardiologist told them to.

**DISCUSSION**

AF is a complex condition and its association with underlying cardiovascular comorbidities and risk factors makes the treatment a very complex process. One can imagine that it is difficult for patients to understand this process and to understand the association between AF, medical treatment and risk factors.

In this study we examined the effect of a specialized outpatient AF-clinic on a large university hospital in Denmark by following a group of patients during the consultations. Our study showed that providing extensive information on AF in a complex situation made it difficult for patients to understand AF and why treatment (especially anticoagulation) was prescribed. Furthermore, our study shows how an AF-clinic provides structured care in a professional and confidence-inspiring way. Communication between health care professionals and patients was dominated by medical aspects with patients having a more passive role. The most valued information for the patients was to hear that their AF was not a fatal condition intrinsically. Nevertheless, mortality does not only relate to AF but also to underlying (cardiovascular) co-morbidities and risk factors (Kirchhof et al. 2016), and these issues were not discussed with the patients.

The AF service as described in this paper can be interpreted as an integrated approach to care, which facilitates guideline-adherent management for AF patients provided within a multidisciplinary team approach, with the main goal to improve
outcomes. This is in line with recommendations from the recently published ESC guidelines on the management of AF stating that structured organisation of care and follow-up should be considered in all patients with AF, to improve guideline adherence but also to keep patients out of hospital and reduce mortality. Guidelines advocate for a patient-centred approach where patients should be placed in a central role in the decision making, in order to individualize the care to patient needs and preferences and also improve adherence to long-term treatment. Before patients can take these important roles, tailored patient education is of the utmost importance and is recommended in all phases of AF management (Kirchhof et al. 2016). However, in this study it was demonstrated that this was not completely the case. When patient’s understanding of their condition is lacking, it is difficult for patients to understand symptoms and participate in their own care process is, as demonstrated in this study.

Furthermore, our research showed how visiting the AF-clinic was overwhelming with complicated information to understand in a short time. Overwhelming information may increase the risk of not understanding the effect of medical treatment, and reduce patient involvement in decision making about choice of anticoagulation treatment. A consequence may be that patients do not take anticoagulation as prescribed, with potential ischaemic stroke (Berian & Livingston 2015) or brain haemorrhage (Deitelzweig et al. 2013, Vestergaard et al. 2016) as a fatal complication. According to a report from the World Health Organisation in 2003, non-adherence may be caused by social economic conditions or influenced by several factors in the health care system or related to the individual patient. The consequences of poor adherence are poor health outcome and increased health care costs (Sabaté 2003). During the interviews, the patients in our study expressed
their concerns about taking medication altogether. A review from 2005 concludes that non-adherence is not due to failure of patients, doctors, or the system but a general reluctance of patients to take medicine (Pound et al. 2005).

The recent ESC guidelines on the management of AF recommend patient involvement in decision making about medical treatment since it has a positive effect on adherence (Kirchhof et al. 2016). It is crucial that patient involvement requires patient education as well as attention to interpersonal aspects in the consultation situation (White et al. 2013). Active patient involvement relates to how patients are able to prepare before decision-making, how they receive information during consultation which can improve their understanding of their own situation, and how they are able to attend follow-up consultations with health care professionals (Siouta et al. 2015). In our study, patients were not so much involved in their care. Active involvement requires health care professionals to invite patients for active participation. Most patients in our study did not ask for further information at the end of consultations, even though they were invited to do so, and even though they did not understand the link between AF, stroke, and anticoagulation. They took the medicine as prescribed and did not want to be involved in decision-making about treatment. As shown by Borg Xuereb et al. (Borg Xuereb et al. 2012), some patients want to be an active part of treatment decision-making, while others are satisfied to leave it to the expertise of the health care professionals. Health care professionals as well as patients need to become more comfortable and confident with decision-making, including medical evidence (objective) as well as life context for patients (social and subjective world) to ensure the best treatment decisions (Kirchhof et al. 2016, Martin et al. 2005).
A Swedish study shows that patients need a sense of trust in the care they receive as well as to feel secure in patient-centred communication, which can be created by a patient involving approach during consultations (Siouta et al. 2015). Patient-centred care empowers patients and respects patient values, preferences and needs (Kirchhof et al. 2016). In some way, this is opposite to the tendency over the last decades to have more task-oriented consultations, where patients talk less, whilst health care professionals provide medical information (Butalid et al. 2014). The same tendency was present in our study. Consultations were handled in a professional way by the cardiologist and the nurses, who followed a medical and disease approach in the communication between them and the patients. Patients were more or less silent and did not talk about their thoughts of AF and their fear of dying before the first consultation. A Dutch study shows how nurses performed outpatient consultation based on a conventional medical model of medical history taking. The authors conclude that it is not beneficial for self-management support, when little attention is paid to patients' perspectives on their illness (Ter Maten-Speksnijder et al. 2016). According to Kleinman et al. (Kleinman et al. 2006), there is an important distinction between disease and illness. Disease focuses on malfunctioning biological processes in patients whereas illness focuses on personal reaction to the disease. There needs to be more attention to the patient’s perspective of his or her situation as an illness, using questions such as: “What do you think sickness does to you?” or “What do you think caused your problem?” In that way, clinicians show concern about how patients react to sickness and how it affects patients’ daily life (Kleinman et al. 2006).

Furthermore, at the organisational level, integrated care with a patient-centred view (Kodner & Spreeuwenberg 2002) and an interdisciplinary approach (Körner 2010)
supports nurses and cardiologists to work closely together and form an AF treatment team. Consequently, patients are educated and involved in their care process and become an active partner in shared decision-making on treatment, care and lifestyle aspects of AF (Hendriks & Strömberg 2015).

In our study, patients with asymptomatic AF, detected by coincidence by their GPs were very surprised that they were having AF. Asymptomatic patients seemed to have difficulties accepting AF as a chronic disease and hoped treatment would cure AF. The GP is important in detecting AF, and the ECS guidelines (Kirchhof et al. 2016) demonstrate the importance of screening in older populations using either pulse palpation or short-term ECG to detect undiagnosed or silent AF (Kirchhof et al. 2016). Patient education is recommended in all phases of AF management to support patients’ perception of AF and to improve management (Kirchhof et al. 2016). As a consequence, patients should be informed about AF and how medical examination takes place at the AF outpatient clinic before the first consultation, and tailored follow-up education during AF management should be initiated.

Patients with mild AF-symptoms pre-consultation tried to explain their symptoms as a consequence of age or physical deconditioning. Consequently, they did not consult their GP or considered that they had a heart disease. Previous research indicates that symptoms can be misinterpreted by patients, and by healthcare providers who dismissed symptoms as insignificant and thereby delayed diagnosis and medical treatment. Instead, patients made self-care strategies such as rest, or avoiding particular activities to manage symptoms (January et al. 2014).

Patients with severe symptoms were afraid of dying during attacks and described the importance of being told by health care professionals that they were not going to die from AF. They explained that later recurrences of AF-symptoms resulted in less
concern. As reported by McCabe et al. it is important for patients to find meaning in symptoms which are closely associated to diagnosis verification and initiate AF-treatment. By providing this information to patients, the professionals give relief to those who had been seeking an explanation for symptoms and validation that they were not “crazy” (McCabe et al. 2011) or as stated in our study ´not going to die´.

**Study limitations and strengths**

First, this is a single centre study, and the number of health professionals involved was small. It would be of value to investigate several outpatient clinics for patients with AF that follow such structured approaches and involve a larger group of consulting health professionals.

Second, fieldwork with the presence of a researcher during consultations may in some way have influenced the behaviour of health care professionals as well as patients, and consequently may have affected how patients experienced the consultations. At the same time, the researchers’ presence yielded valuable incremental information and insights over only interviewing patients. Furthermore, being present as researcher during consultations qualified the interviews, since the researcher could refer to the actual situations from the consultations and ask patients to reflect on them.

Finally, only a small number of patients were involved in the study and a larger group of informants could probably have supported transferability to other settings more strongly. However, the strength of this study is that all patients were referred from a GP to the outpatient clinic with newly diagnosed AF, but without a final AF-diagnosis made by the GP before first AF-clinic consultation.
CONCLUSION

This study indicates how patients were uncertain on AF before as well as after consultation even though consultations were performed in a professional and confidential way. The communication was concentrated on the medical aspects of atrial fibrillation and visiting the clinic was an overwhelming experience. Patients had difficulty understanding why they were treated with anticoagulation, and that it was a lifelong treatment.

RELEVANCE TO CLINICAL PRACTICE

This study demonstrates some lack of patient-centred care and an absence of tailored patient AF-related education within the specialized AF-clinic. Patients were referred from the GP without preparing the patients for the AF-clinic and the professionals were not aware of these circumstances. The study highlights the need and importance of active patient involvement in consultations and decision-making by taking into consideration patients’ values and beliefs as well as knowledge about AF as a starting point.

There is a need of more knowledge of how consultations in other AF-clinic settings are performed, how consultation affects patients handling AF and how AF affects health related quality of life over time.

References


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Table 1 Characteristics of the participants

<table>
<thead>
<tr>
<th>Pseudo initials</th>
<th>Sex</th>
<th>Age</th>
<th>Consultations number, clinicians</th>
<th>Symptoms</th>
<th>Numbers of consultations in all (N=42)</th>
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</thead>
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<tr>
<td>HN Female</td>
<td>66</td>
<td>1. HRS* 2. Nurse C)</td>
<td>Intermittent. Only few symptoms</td>
<td>2</td>
<td></td>
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<tr>
<td>EH Male</td>
<td>74</td>
<td>1. HRS 2. Nurse L)</td>
<td>Permanent. No symptoms</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>AH Female</td>
<td>71</td>
<td>1. HRS 2. Nurse C)</td>
<td>Intermittent. Periodic palpitation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>JT Male</td>
<td>63</td>
<td>1. HRS 2. Nurse C) 3. Nurse L</td>
<td>Permanent. Few periods with dyspnoea</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>AD Female</td>
<td>77</td>
<td>1. HRS 2. Nurse C)</td>
<td>Permanent. No symptoms</td>
<td>2</td>
<td></td>
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<tr>
<td>IC Female</td>
<td>67</td>
<td>1. HRS 2. Nurse C)</td>
<td>Permanent. Fatigue</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>IL Female</td>
<td>70</td>
<td>1. HRS 2. Nurse L) 3. Nurse C)</td>
<td>Intermittent. Few periods with palpitation</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

* HRS= Cardiologist who was a Heart Rhythm Specialist
Table 2 Units of meaning, units of significance and main theme: “Visiting the clinic – an overwhelming experience”

<table>
<thead>
<tr>
<th>Units of meaning</th>
<th>Subthemes</th>
<th>Units of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(What the text is saying)</td>
<td>(What the text speaks about)</td>
<td></td>
</tr>
<tr>
<td>HN: “After the first consultation we did not know much more information about the name of the game. No, I do not think so. I did a google search afterwards and know where I can find more.”</td>
<td>Difficult to understand</td>
<td></td>
</tr>
<tr>
<td>After consultation: NH: “I need to go to my general practitioner and hope, that he can explain my what kind of disease I have and what is going to happen.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JA: “No – I cannot tell you what atrial fibrillation is and why I am treated as I am. (Pause) I really do not understand what kind of disease I have. But I do take the medicine as prescribed”</td>
<td>Difficult to describe AF and knowledge after consultations are medical treated as I am.</td>
<td></td>
</tr>
</tbody>
</table>

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Table 3 Results Themes and subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertainty about the atrial fibrillation</td>
<td>Pre-consultation knowledge</td>
</tr>
<tr>
<td>before first consultation</td>
<td></td>
</tr>
<tr>
<td>Focus on the medical aspects of atrial fibrillation</td>
<td>Beginning consultation with medical examination</td>
</tr>
<tr>
<td></td>
<td>Not knowing what to ask for</td>
</tr>
<tr>
<td>Atrial fibrillation is not a fatal disease</td>
<td>Metaphors</td>
</tr>
<tr>
<td></td>
<td>Fear of dying</td>
</tr>
<tr>
<td></td>
<td>Crucial information</td>
</tr>
<tr>
<td>Professionalism and competence in the care of atrial fibrillation</td>
<td>Confidence inspiring way</td>
</tr>
<tr>
<td></td>
<td>Taking time</td>
</tr>
<tr>
<td>Visiting the AF-clinic – an overwhelming</td>
<td>Precondition before consultation</td>
</tr>
<tr>
<td>experience</td>
<td>Information during consultation</td>
</tr>
<tr>
<td></td>
<td>Knowledge after consultations ended</td>
</tr>
</tbody>
</table>