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Is the Therapeutic Relationship Considered When Planning Patient Decision Aids Implementation for Implantable Cardioverter-Defibrillator Therapy? A Qualitative Investigation

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Abstract

Background: *Shared decision-making relies on patients and clinicians establishing a partnership. Patient decision aids (PDAs) can facilitate shared decision-making. The role of therapeutic relationships (TR) in PDA implementation has not been investigated.*

Objective: *To explore how the TR is considered when planning PDA implementation for patients eligible for or with an implantable cardioverter-defibrillator (ICD).*

Methods: *Secondary qualitative analysis using Thorne's interpretive description approach. Thematic analysis of five individual interviews and four focus groups of patients with ICDs and their family members, nurses and physicians.*

Results: *We revealed three themes. Pieces of the relational puzzle, as participants identified communication, respect, empathy, and trust as important to PDA implementation. Clinicians reported Good intentions, and challenges for building a TR, including time and discomfort with ICD-related discussions. Finally, participants believed PDAs can help foster the TR.*

Conclusion: *Some elements of the TR are deemed relevant when planning PDA implementation.*

Keywords: implantable cardioverter defibrillator, patient decision aids, decision support, therapeutic relationship, qualitative

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Key Highlights

- Certain elements of the therapeutic relationship, in particular therapeutic communication, respect, empathy, and trust, are important for patient decision aid implementation.
- Clinicians have good intentions for establishing therapeutic relationships but face challenges.
- Patient decision aids can help foster elements of the therapeutic relationship during shared-decision making encounters.

Introduction

Implantable cardioverter-defibrillators (ICDs) are surgically implanted devices that detect and treat ventricular arrhythmias. In appropriately selected patients, they decrease the risk of sudden cardiac death (SCD; Bardy et al., 2005; Bennett et al., 2017; Moss et al., 2002). Despite its potential life-saving capacity, ICD therapy has risks including procedural risks (Nery et al., 2010; Poole et al., 2010), inappropriate shocks (Daubert et al., 2008; Peterson et al., 2017), psychological harms (Kapa et al., 2010), and potential suffering at end-of-life from repeated shocks (Goldstein et al., 2004; Stromberg et al., 2014). As such, patients identified as candidates for an ICD or those with an ICD need to weigh these risks and potential life-saving benefit when faced with the preference-sensitive decisions of whether to implant the device, replace the pulse generator, or deactivate the tachytherapies when nearing end of life (Lewis et al., 2014). Clinical practice guidelines recommend eliciting and integrating patients' informed values and preferences when considering these decisions (Al-Khatib et al., 2018; Philippon et al., 2017). This approach is referred to as shared decision-making (SDM).

Shared decision-making requires that patients and clinicians collaborate to make decisions. Clinicians provide their expertise on the health condition, the treatment options, and the risks and benefits of these options; whereas patients share their expertise on their personal situation, and what matters most to them (Makoul & Clayman, 2006). Interventions to facilitate this process include patient decision aids (PDAs; Alsulamy et al., 2020; Stacey et al., 2024). Patient decision aids are evidence-based interventions that explicitly state the health decision, describe the health condition, present the options with the risks and benefits, and help patients clarify their values for features of treatment options (Joseph-Williams et al., 2014; Stacey et al., 2024). A systematic review of 209 trials demonstrated high certainty of evidence that in comparison to usual care, PDAs improve patients' knowledge, accuracy of risk perceptions, decrease decisional conflict related to feeling uninformed and unclear personal values, and result in people being more active in decision-making (Stacey et al., 2024). Patient decision aids also increase patients' satisfaction with the decision-making process (Stacey et al., 2024).

Several SDM models discuss the importance of building a partnership between the clinician and patient, which is defined as a collaborative relationship focused on a shared goal (Bomhof-Roordink et al., 2019; Lewis et al., 2016; Makoul & Clayman, 2006). Partnerships between clinicians and patients result in better communication and participation in decision-making (Loiselle et al., 2021; Stacey et al., 2020). When these partnerships are established to gain an understanding of the patients' experiences of their health condition and considers feelings and attitudes that the patient and clinician have toward one another to limit power imbalances, this is referred to as a therapeutic relationship (TR; Doherty & Thompson, 2014; Mirhaghi et al., 2017; Phaneuf, 2011; Sylvestre & Gobeil, 2020). They are goal-directed and composed of several elements including empathy, trust, respect, genuineness, manifesting a presence, therapeutic communication, active listening, and reciprocity (Table 1; Kornhaber et al., 2016; Sylvestre & Gobeil, 2020). Grounded in a caring, supportive, and non-judgemental interpersonal process, TRs are central to nursing practice. Carroll et al. (2011) revealed that patients' trust in the physician and nurses positively influences ICD decision-making processes. Although trust and communication have been reported as facilitators to SDM (Covvey et al., 2019; Waddell et al., 2021), SDM models have yet to break down these partnerships into these key elements and consider their role in the delivery of decision support interventions. Little is known about how the elements of the TR – and the TR as a whole – influence PDA implementation (Joseph-Williams et al., 2021; Yu et al., 2019). The overarching aim of this research is to explore how the TR is considered when planning PDA implementation for patients eligible for or with an ICD. Understanding if, when, and how patients and clinicians consider the TR during the decision-making process may provide some insights into how PDAs can be used to support SDM in clinical practice.

Methods

Study Design

We conducted a secondary qualitative analysis using Thorne's (2016) interpretive description approach. We analyzed transcripts of individual interviews and focus groups from a multisite comparative case study that aimed to investigate effective approaches for the implementation of PDAs

Table 1

TR Elements and their Definitions[1]

TR Element	Definition
Active listening	Listening to hear and to understand the patient
Empathy	A sentiment of profound comprehension from the HCP toward the patient
Genuineness	Ability to be open and honest with the patient
Manifesting a presence	Being physically and psychologically present with the patient during encounters
Respect	Acknowledging the value of patients and accepting their individuality as well as their unique needs and rights
Reciprocity	Refers to the balance of giving and receiving in a relationship with the goal of creating a healthy and mutually beneficial partnership
Respect	Acknowledging the value of patients and accepting their individuality as well as their unique needs and rights
Therapeutic communication	Interpersonal exchange, using verbal and non-verbal messages, that expresses support, provides information and feedback, corrects distortions, and provides hope
Trust	A justified expectation that one can depend on another person's promise, commitment, or responsibility

Note. [1](Browne, 1993); (Geller, 2020); (Horner, 2020); (Phaneuf, 2011); (van Servellen, 2009), and (Yu et al., 2019).
TR = therapeutic relationship; HCP = healthcare professional.

(Lewis et al., 2022). Transcripts were re-analyzed specifically to explore the elements that contribute to TR during the PDA implementation planning process. A secondary analysis is justified as the focus on the TR and its elements is closely aligned with the parent study's objective to investigate the factors influencing the implementation of PDAs to facilitate SDM for ICD-related decisions (Lewis et al., 2022). In addition, our research questions are consistent with the evidence that patients are engaged better in decisions when receiving individualized decision support from clinicians (Lewis et al., 2018). We report the study using the Standards for Reporting Qualitative Research (SRQR) guidelines (O'Brien et al., 2014). The University of Ottawa research ethics board approved this secondary analysis (H-11-22-8655). With informed consent provided for the parent study, participants had agreed to their data being used for subsequent studies.

Theoretical Underpinnings

According to the Ottawa Decision Support Framework (ODSF), patients make informed and values-based decisions when their decisional needs are met– the ultimate goal of the PDAs that we intended to implement (Hoefel et al., 2020; Stacey et al., 2020). The ODSF was used in the parent study to guide the PDAs, desired outcomes, and support the establishment of a relationship between clinicians and patients. However, the latter has been poorly described in the ODSF. As such, we integrated theoretical writings on elements of the TR including its various elements, forming a theoretical scaffolding as per Thorne's interpretive description approach (Geller, 2020; Horner, 2020; Phaneuf, 2011; van Servellen, 2009; Thorne, 2016; Yu et al., 2019).

Research Characteristics and Reflexivity

The research team was comprised of a graduate student and cardiovascular nurse (AV), who value and prioritize the relational aspect of health care; faculty advisors (DS, JC, HS, SLC, and KBL), all of whom are registered nurses and university faculty members; and an advanced practice nurse in cardiac supportive and palliative care for patients with cardiac conditions (FK). Team members believe that building relationships with patients, therapeutic or otherwise, better position clinicians to support patients and their decision-making needs. Team member expertise included patient decision aids (DS, SLC, KBL), arrythmia care (FK, SLC, KBL), TR (JC, HS), and supportive and palliative care (FK). The parent study was led by the supervising author (KBL) with collaboration from co-authors (DS, SLC). We acknowledge our team does not represent the views of all those involved in the care of patients making decisions about ICDs.

Setting and Participants

Participants were recruited from one specialized arrhythmia site in Ontario, Canada, serving a geographic region of about 1.3 million patients. Annually, the hospital performs on average 280 new ICD implants and 170 replacements (Electrophysiology Triage Coordinator, Personal Communication, May 2023). We re-analyzed the transcripts of five individual interviews and four focus groups, including patients and family members who had an ICD or a non-replaced/deactivated ICD within the last year, and clinicians with more than one-year experience working with and making ICD-related decisions with patients and families.

Data Collection

Participants provided written informed consent as part of the parent study. Interviews/focus groups were 45–60 minutes in length with some conducted in person and others via video call due to data collection taking place pre- and post-COVID hospital lockdowns (February 2020 to September 2021). Individual interviews and focus groups were audio-recorded, transcribed, and deidentified. Ahead of their scheduled interview, all participants were sent the suite of three PDAs in both paper and electronic formats (for initial ICD implantation, pulse generator replacement, and deactivation), details of which are reported elsewhere(Carroll et al., 2013, 2017; Heart and Stroke Foundation of Canada, n.d.; Lewis et al., 2018, 2021). The PDAs are freely available here https://icddecisionaids.ca/.

Data Analysis

We re-analyzed de-identified transcripts in two groups: patients/family members, and clinicians, guided by Braun and Clarke's (2006) thematic analysis, an accepted data analysis method according to Thorne's interpretive description approach. We used an inductive and iterative approach. Team members (AV, FK) independently read and re-read the transcripts to become familiar with the data; organized data systematically with open coding; and, as relevant, mapped preliminary codes onto TR elements. We captured both explicit and implicit mention of the TR and its elements. We inferred implicit mention by referring to the elements' definition and discussing whether the data represented it. Transcripts were re-examined for similarities and differences, and to ensure that newer codes were reflected in initially analyzed transcripts. AV, FK, and KBL reviewed, discussed, and modified the preliminary codes and grouped them into themes, ensuring that they were supported by the data, coherent, and distinct. All team members reached consensus about the themes through discussion.

Results

We included 10 patients, three family members and 17 healthcare professionals (Table 2). Patients and family members varied in age with nearly half (*n* = 6; 46.2%) 50–59 years old and most self-identifiying as men (*n* = 9; 69.2%). More than half (*n* = 7, 53.8%) reported a preference for sharing decisions with their clinician, while five participants (38.5%) preferred to make the decision on their own. Clinicians were all under 60 years old and most self-identified as men (*n* = 10; 58.8%). Some had worked with patients with ICDs for less

Table 2

Participant Characteristics

	Patients (*n* = 10)	Family members (*n* = 3)	Clinicians (*n* = 17)
Age (years)			
18–49	1 (10.0%)	1 (33.3%)	11 (64.7%)
50–59	5 (50.0%)	1 (33.3%)	6 (35.3%)
60–69	1 (10.0%)	1 (33.3%)	
70–79	3 (30.0%)		
Gender			
Men	8 (80.0%)	1 (33.3%)	10 (58.8%)
Women	2 (20.0%)	2 (66.7%)	7 (41.2%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)
Education level			
Some high school/elementary school	1 (10.0%)		
High school graduate	4 (40.0%)	1 (33.3%)	
Some college or university	3 (30.0%)		
University degree	2 (20.0%)	2 (66.7%)	
Post-graduate university degree			
Clinician role			
Cardiologist			1 (5.9%)
Electrophysiologist			6 (35.3%)
EP Fellow			4 (23.5%)
Registered nurse			6 (35.3%)
Experience with ICD in years			
Less or equal to 5	5 (50.0%)		6 (35.3%)
6–10	4 (40.0%)		3 (17.6%)
11–15	0 (0.0%)		2 (11.8%)
More than 16			3 (17.6%)

Note. EP = electrophysiologist; ICD = implantable cardioverter defibrillator.

than 5 years (*n* = 6; 35%) and others for more than 16 years (*n* = 3; 17.6%). The sample included people who identified as Caucasian, Black North American, East Indian, Latin American, West Indian, Asian and West Asian. We revealed three themes, along with subthemes, presented below.

Pieces of the Puzzle: Some Elements of the Therapeutic Relationship

Participants did not mention the TR by name, yet two of its elements, respect and therapeutic communication, were frequently identified as important for PDA use. Participants also referred to empathy and trust, but implicitly. Genuineness, active listening, manifesting a presence, and reciprocity were not mentioned.

Therapeutic communication was similarly understood by both groups as the sharing of helpful information to make informed and values-based decisions. In many of the instances described, therapeutic communication fell short. Shortcomings were primarily related to information not being shared or from misunderstandings. Patients and family members reported inadequate knowledge about the ICD and potential future ICD-related decisions. A family member (Patient-Family interview – Participant 2), whose spouse was eligible for an initial ICD, reported:

> *There's a lot of information that I still feel I'm lacking. I know that at one point I might have to make some tough decisions but also the more information I have the better I will be equipped and the more I can gently approach the subject with him to find what his wishes are.*

As a result, some patients and family members took it upon themselves to seek their own information. A patient (Patient Interview – Participant 7) reported:

> *I honestly did not think I'd be able to find the answers to all my questions or get them. I was basically writing them down to ask the doctor and I ended up finding most of them in literature before I even met with the doctor.*

These accounts highlighted that patients and family members want and need to be informed from reliable sources to participate in decision-making. Clinicians shared different perspectives. Some reported having conversations with patients and their intentions of sharing information about potential future decisions. An electrophysiologist (Physician focus group- Participant 9) explained their usual script when meeting patients about initial ICD implantation:

> *When we first meet patients and discuss the implantation of an ICD, we talk to them and explain that it fits them for their current circumstance, but those circumstances do change and setting the scene early on means that we build upon that later and particularly when you have the more difficult discussion about deactivation of the device.*

A nurse (Nurse focus group-Participant 2) reported that patients do not always understand the ICD's purpose and its implications:

> *A lot of the times people are being implanted where they're not necessarily aware of the decision that's being made. Like, if they come in with an MI (myocardial infarction) and they end up with an ICD, then it's like, "Well you know, what do you mean I have this?"*

Participants from both groups identified *respect* as important for PDA implementation. Participants understood it as respecting the patient's role and voice in the decision-making process. A patient (Patient interview-Participant 8) described learning about the option of ICD deactivation: *"They told me about that, I could choose to have it turned off if at any point I no longer want to use it."* A nurse (Nurse focus group-Participant 4) shared an encounter during which she acknowledged the importance of eliciting a patient's personal values and preferences and allowing choice:

> *One of [physician's name]'s cases, Lyme Disease. Now he doesn't need it [ICD]. Do you remove it [ICD]? Right? More than likely his choice is going to be to keep it. … I'd be like get it out, but so you don't know where people's minds are at.*

Participants (Patient interview-Participant 10) also shared experiences of not being presented with options, as evidenced by this quotation: *We weren't asked very much. It wasn't like, you know, "do you want one, yes or no." It was more like "you need one. Here it is."*

In the setting of ICD battery depletion, automatic replacement suggested that respect for the patient's voice and wishes may have been overlooked. A nurse (Nurse focus group-Participant 7) offered an example:

> *They don't really think there's a decision there, it's just work. Physicians were coming in and just saying, "There we go" and ... So, there's almost like not an open decision… I mean in certain situations where you think oh is this really something and then it gets discussed. But generally, with a lot of people it's just, oh the battery's low.*

Both participant groups raised the importance of *empathy*. Patients and family members considered themselves the *recipients* of empathy; and described it as being reassured by clinicians who elicited and acknowledged their personal preferences and concerns. Clinicians considered themselves as the *givers* of empathy, placing themselves into their patient's situation and offering supportive measures. Another patient (Patient interview-Participant 8) described empathy as a personal, intrinsic characteristic that is displayed in various degrees from one clinician to another: *"I mean don't get me wrong. Doctors are trained, but they're not necessarily skilled in that field. They don't all have the same amount of empathy."*

Patients and family members talked about *trust* as having confidence in the clinician, being comfortable with them and able to speak when desired. Clinicians described trust as being open and honest with patients and having their best interest at the forefront of their care. Patients and family members had mixed experiences with trust in ICD-related healthcare encounters. Clinicians considered themselves as trustworthy.

A patient (Patient interview-Participant 7) reported feeling confident in their clinician when considering their options at initial implantation:

> *I was super-impressed with that because I've dealt with a lot of doctors where the bias is the only thing that's influencing your decision. So, yeah, I had a lot of confidence in my medical team because of that.*

Another patient (Patient-Family focus group – Participant 4) shared a different perspective, doubting their clinician's commitment, sharing:

> *They always open the door and say you can talk with your doctor. So, confusion. I'm going to send a lot of emails to my doctor to ask him about if I can use my massage, my mobile massage machine. I'm not sure, he has a lot of things to do, right? He has a lot of patients. I'm not sure that he will have time to respond to me.*

In this patient's case, discrepancies between messages and action hindered trust between them and their clinician. An electrophysiologist (Physician focus group – Participant 9) described trust as the acknowledgment of the individuality of patients and the importance of their personal beliefs, support, and context and how these should be viewed alongside the research evidence:

> *It's such a mixture, isn't it, of someone's understanding, their beliefs, their family, those sorts of situations and I think the tools help us to see one thing from an information, from a research perspective maybe, what's the true risk for the patient?*

Good Intentions and Challenges of Establishing a Therapeutic Relationship

For patients, building relationships was about achieving connection and comfort with their clinicians. A patient explained: "*I've reached out to (name1) because I feel more comfortable speaking with her one-on-one rather than taking (name2)'s time*" (Patient-Family interview – Participant 1), a relationship that turned out to be very helpful for them for many years. Clinicians described good intentions for establishing relationships with their patients, speaking of their intentions to ensure therapeutic communication and respect. A nurse (Nurse focus group-Participant 3) reported their positive intentions about sharing information and respecting the patient's perspective at ICD replacement:

> *I think that it's part of the informed consent. If you're going to go on having a replacement, the patient should have all the information possible for making that decision whether they want it replaced or not.*

A frequent challenge raised by clinicians was that of insufficient time. An electrophysiologist (Physician focus group-Participant 10) suggested a way to overcome this:

> *I think that a proactive approach might be the way to mitigate the issue of the time crunch and supply that information there or if we have some kind of like a follow-up conversation that someone calls them, whether it's, you know, one of the nurses or one of the physicians or a combination, or whatever. To, outside of the hectic time crunch that device clinic is, initiate that conversation so that it's separate, and you don't have the same pressure.*

Other clinicians discussed their discomfort navigating ICD decision-making encounters. A nurse (Nurse focus group-Participant 4) shared the following concern:

> *I feel like I wouldn't know what to say because we're so not used to talking about it. I would need some practice maybe to introduce the subject or because they'll have questions, like "What do you mean? I can have… there's an option that I can have it, like just leave it there?" So I would probably have to be more knowledgeable myself first.*

Clinicians reported wanting to engage with their patients, yet discomfort rooted in limited knowledge and skills on navigating ICD decision-making discussions made it difficult to do so.

PDAs can Help Foster Elements of the Therapeutic Relationship

All participants spoke about ways in which the PDAs could facilitate therapeutic communication and respect. The PDA was valued by both groups for its ability to offer evidence-based information. The clinicians considered the PDA a useful tool to initiate conversations about issues that they may otherwise find difficult to introduce, such as ICD non-replacement and deactivation. A nurse (Nurse focus group-Participant 4) shared her view on using the PDA about deactivation:

> *Even if they've seen it almost at implant and then [deactivation] is easier to bring up depending on the person, their cognition, it's not like you're just sort of at the last-minute saying, "So what are you still doing with that?"*

With the PDAs explicitly listing treatment options, it fulfills the element of respect. A patient (Patient interview-Participant 7) stated: *"I think that probably the single most important precursor of any of these documents is like, your doctor may be telling you that you need this, but you need to decide what's right for you."* Clinicians agreed, further adding that the PDA can enhance patient knowledge about the options available. A nurse (Nurse focus group – Participant 1) shared her perspective about the PDA for battery replacement: *"And to realize, that you've got an option, it's not just like, we're okay we're coming back to replace, it's like you feel like you've got some options here."*

Many patients and family members affirmed that the PDAs should not stand alone and be used with the clinician, giving opportunity to foster TRs. This opinion was grounded in a patient's (Patient interview – Participant 7) prior experience with a PDA:

> *That's one thing I worry about with decision guides too, is that the only time I've ever been given one was in a hospital where doctors did not talk to patients. So, I do kind of worry about them being used as a replacement for doctors actually being available to answer questions.*

Discussion

We explored how the TR and/or its elements are considered when planning the implementation of PDAs for patients facing decisions about ICD therapy. Not one participant mentioned the TR by name, yet many raised TR elements, both explicitly and implicitly. Our findings also suggest that PDAs can facilitate TR elements within an encounter. Our observations lead us to three main points of discussion: 1) the importance of TR, 2) the importance of using/revising PDAs with patients in encounters, and 3) the integration of TR knowledge and skill-building in interprofessional SDM team training.

The TR and its elements are important to patients' health experiences, yet many of its elements are overlooked in the context of decision support. A systematic review of 40 SDM models, frameworks, and theories identified fostering a partnership as an important feature to both patients and clinicians (Bomhof-Roordink et al., 2019). An integrative review of 52 articles revealed relationship building as the first step to SDM in a nursing SDM model (Truglio-Londrigan & Slyer, 2018). The ODSF also integrates establishing a rapport in its framework (Stacey et al., 2020). Yet, existing SDM models, frameworks, and theories have yet to dissect these steps in the foundational elements required to build relationships and rapport, as done with the TR. In our study, only two of eight TR elements were explicitly identified (i.e., therapeutic communication and respect) and two others implicitly identified (i.e., trust and empathy) which is in keeping with previous studies that have raised the relevance of these elements for SDM (Alsulamy et al., 2020; Carroll et al., 2011; Covvey et al., 2019; Kalocsai et al., 2018; Pel-Littel et al., 2021; Waddell et al., 2021; Yu et al., 2019). Humanistic communication has recently been raised as important to SDM encounters and aligns with some of the TR elements, such as therapeutic communication and respect (Kunneman et al., 2019; Zisman-Ilani et al., 2023). It originates from a commitment to the dignity of each person while actively listening, respecting the patient, acting with compassion, integrity, and empathy in both the manner and the content of interactions, which has been shown to contribute to quality decision-making processes and better patient-clinician relationships (Kunneman et al., 2019; Santema et al., 2017). Kunneman et al.'s (2019) systematic review on humanistic communication emphasized that warmth, interest, and empathy have been neglected in SDM research. Their findings indicated that SDM evaluation studies tend to focus primarily on technique, such as providing information rather than the quality of the interaction (Kunneman et al., 2019). In another study, clinicians believed that the PDA changed the way they approached the encounter, which is similar to our findings that the PDA can help foster elements of the TRs (Fay et al., 2016). Hence, PDAs may offer an opportunity to promote TRs. In future research, observing interactions between patients and clinicians when P DAs are in use may be useful to gain a more accurate understanding of the depth of therapeutic relationships during SDM encounters. Feelings and emotions between patients and clinicians also play an important role in therapeutic relationships. Further research is required to explore the role and presence of feelings and emotions during interactions that incorporate PDAs.

In the context of ICDs, a potentially life-saving intervention, PDAs are to be used within an encounter. If used alone, the PDA content may be insufficient to support the decisional needs of patients with ICDs, and may not reach their potential (Stacey et al., 2024). This aligns with Rao et al. (2022) who concluded that a mandate focused on PDA use alone to support ICD decisions was insufficient to improve decision-making and decision quality outcomes. This was also suggested by Lewis et al. (2018, 2021), who recognized the need for physicians to tailor a PDA with nurse-led decision coaching based on patients' needs. Cardiovascular nurses can establish TRs and engage patients in decision-making using PDAs and decision coaching. This could help mitigate the barrier of time. (Lewis et al., 2016).

Knowledge and skill-building for establishing TRs could be integrated into interprofessional team training for PDA implementation. For instance, the Ottawa Patient Decision Aids Group offers a communication skill tool based on the ODSF to support therapeutic communication when providing decision support (Bunn et al., 1998). This tool provides key communication techniques such as listening and questioning, and how to provide information or offer feedback (Bunn et al., 1998). Gutman et al. (2021) adapted and evaluated a SDM training module for healthcare professionals. This training module integrated content related to elements of collaborative relationships and the contributions of PDAs to the SDM process using a range of interactive methods (e.g., slide presentations, group exercises and discussions; Gutman et al., 2021). Participants reported difficulty introducing the principles of SDM into their relationship with patients and faced challenges such as time, as similarly reported in our findings (Gutman et al., 2021). Establishing TRs or partnerships are often not integrated in training. Our findings suggest that it would be pertinent to consider, especially when planning to implement PDAs.

Strengths and Limitations

According to Lincoln and Guba's (1985) criteria to enhance the trustworthiness and credibility, an audit trail was maintained. Further, triangulation occurred at the level of the data sources between patients/family and clinicians, and at the level of data analysis by various team members with different roles and perspectives. For this secondary analysis, we used data collected from one site, and from patients with an indication for ICD without cardiac resynchronization. It is possible that patients, family members, and clinicians from other sites and with other types of cardiac devices have different experiences and expectations. Although many ethnicities/races were represented in our sample, further cross-cultural research is indicated to explore the transferability to other clinical and cultural contexts. Given the secondary use of data, interview questions did not explicitly pertain to the TR. Hence, the lack of mention of the elements of genuineness, active listening, manifesting a presence, and reciprocity, does not mean they are not important. Primary studies are required to investigate this directly. Finally, while secondary analysis findings may not be considered formally transferable, they can further our understanding of the role of the TR when planning PDA implementation in clinical practice.

Conclusion

Our findings suggest that certain elements of the TR, in particular therapeutic communication, respect, empathy and trust, are important for PDA implementation. The TR and its elements should be considered when developing implementation strategies. Further research is needed to explore the role and importance of the other TR elements of genuineness, manifesting a presence, active listening, and reciprocity.

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Conflicts of Interest

None

Disclosures

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