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THE LIVED EXPERIENCES OF NEPHROLOGISTS DURING SHARED DECISION-MAKING FOR DIALYSIS INITIATION IN PATIENTS WITH ADVANCED CHRONIC KIDNEY DISEASE: A QUALITATIVE STUDY

Dr Humera Bukhari[1], Dr. Hashmat Ullah Khan[*2], Prof. Dr. Junaid Sarfraz Khan[3], Dr Ayesha Junaid [4]

[1]Department of Nephrology, Lady Reading Hospital, MTI, Peshawar, Pakistan.
*[*2]Department of Medicine, Lady Reading Hospital, MTI, Peshawar, Pakistan*
[3]School of Health Professionals' Education, Research & Entrepreneurship, Health Services Academy, Islamabad, Pakistan.
[4]Centre for Language Development, Forman Christian College University, Lahore, Pakistan.

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Corresponding Author: Dr.
Dr. Hashmat Ullah Khan

Abstract

Initiating dialysis in patients with advanced chronic kidney disease (CKD) is a consequential decision involving medical, psychological, social, ethical, and financial considerations. Shared decision-making (SDM) provides a framework in which clinicians and patients collaborate to reach treatment decisions that integrate clinical evidence with patient values. However, nephrologists may encounter considerable challenges when facilitating these discussions, and their subjective experiences remain underexplored. This study aimed to explore the lived experiences of nephrologists involved in shared decision-making for dialysis initiation among patients with advanced CKD. A qualitative study with a phenomenological orientation was conducted using in-depth, semi-structured interviews with five consultant nephrologists recruited through purposive sampling from a tertiary care hospital. Interviews explored participants' experiences of discussing dialysis initiation, communication challenges, family involvement, ethical concerns, emotional experiences, factors influencing patient decisions, and perceived strategies for improving SDM. Data were analyzed using reflexive thematic analysis. Trustworthiness was supported through repeated engagement with the dataset, systematic comparison of coded extracts across participants, and maintenance of a reflexive stance. Seven themes were identified: (1) evolving toward patient-centred shared decision-making; (2) early and continuous communication as the foundation of decision-making; (3) bridging fear, misunderstanding, and communication barriers; (4) family involvement as support and source of tension; (5) balancing clinical guidance with patient autonomy; (6) emotional demands, empathy, and professional growth; and (7) systemic and resource constraints shaping meaningful choice. Participants described a shift from disease-centered communication toward greater attention to patient values, quality of life, and personal priorities. Early discussions were considered essential to allow patients and families time to understand treatment options before emergency dialysis became necessary. Fear, misconceptions, limited health literacy, language barriers, financial concerns, and unrealistic expectations complicated communication. Family members were reported as "potential sources of pressure,"

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as well as "important sources of support. Ethical dilemmas arose for participants in cases where clinical recommendations differed from patient preferences, or when there were expected benefits to the treatment that were restricted. These conversations were challenging but were beneficial for developing empathy, patience, and professional development. However, patients were limited in the number of meaningful options available due to systemic factors, such as limited availability of peritoneal dialysis and transplantation, affordability and not enough consultation time. Dialysis initiation is a multi-faceted and ongoing process for nephrologists, not just a biomedical decision. Key elements of effective SDM are early communication, giving individual information, respecting patient autonomy, providing appropriate family involvement, allowing sufficient consultation time, ensuring treatment alternatives are accessible, and ensuring organizational support. The implications of these findings for communication training, service design and nephrology care for patients are discussed.

INTRODUCTION

In advanced chronic kidney disease, discussions often start about kidney replacement therapy. When dialysis is started, it is a significant change in a person's life and can affect activities, independence, family relationships, finances and quality of life (Tong et al., 2014). Therefore, dialysis should not only be considered for patients with a medical indication for dialysis. Shared decision making (SDM) is a patient centered way to deal with these complex decisions (Elwyn et al., 2012). SDM is not just about symptoms, but takes the patient's value, preference, expectation, circumstance and goal into consideration when working with patients. This can be part of the conversation in dialysis decision making around options for dialysis, transplant, conservative, benefits/burdens and how dialysis will impact daily life. But for nephrologists it can be difficult to facilitate SDM. The patients may be afraid of dialysis, feel that they have misconceptions about dialysis, lack health literacy or have expectations that are different from the physician. Family members can have a significant supportive role, but at the same time may put pressure on or have preferences when they are not congruent with the patient's (Tong et al., 2014). Ethical dilemmas can also occur when a patient chooses not to have dialysis because there is a good medical reason for wanting it or when relatives want dialysis but it is not likely to be of any benefit to the patient.

The timing of these conversations is also important. Discussions occurring during an acute or emergency presentation may leave insufficient time for patients and families to understand their choices. In contrast, early communication may provide an opportunity for questions, reflection, family discussion, and consideration of treatment alternatives.

Literature Review

Shared decision-making has been increasingly recognised as a cornerstone of patient-centred care in nephrology. The conceptual foundations of SDM emphasise the integration of clinical evidence with patient values, preferences, and circumstances (Elwyn et al., 2012). In the context of advanced CKD, SDM involves discussions about dialysis initiation, modality selection, transplantation, conservative management, and the anticipated impact of treatment on quality of life.

Previous qualitative research has explored patient and caregiver perspectives on dialysis decision-making. A thematic synthesis of qualitative studies identified several key themes, including the importance of timely information, the emotional impact of dialysis decisions, the role of family support, and the influence of financial and logistical factors on treatment choices (Tong et al., 2014). These studies have contributed to understanding the patient experience and have informed the development of decision aids and communication interventions.

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However, comparatively little attention has been given to the experiences of nephrologists who facilitate these discussions. Medical evidence, patient preferences, family dynamics and constraints in the health care system all play a role in the treatment choices made by clinicians. Their views might highlight communication issues, ethical dilemmas, and organizational considerations that impact effective decision-making and ultimately care of patients. Therefore, it is important to understand the lived experiences of nephrologists for the effective development of communication training, and the improvement of service delivery to enhance the role of communication facilitators in the context of SDM. Qualitative research is well positioned to examine such experiences because it allows for deeper understanding of processes and perceptions and meanings that cannot be captured with quantitative research (Creswell & Poth, 2018). In particular, a phenomenological orientation enables the researcher to explore the ways in which people make sense of their lived experience and to recognise common threads of meaning within the group of participants (Smith et al., 2009). This current study adds to the literature by offering an in-depth, qualitative examination of nephrologists' experience with SDM during dialysis initiation in a tertiary care facility that has a family-centered decision making norm, financial constraints, and limited availability of some treatment modalities. The results could be used to improve communication, promote clinician wellbeing, and help ensure patient-centred nephrology care.

The conceptual model below captures the themes that became apparent during the study and how they relate to shared decision-making in general and to the experience of beginning dialysis. The model is an iterative process that is affected by several factors at the clinician, patient, family, and healthcare-system levels and is not a one-off activity. This model demonstrates that the SDM process for initiating dialysis is not a one-off event, but a process influenced by a variety of clinician factors, communication practices, family circumstances, ethical considerations, emotional responses and systemic factors. All these dimensions are crucial for effective SDM.

Methods

Study Design

Qualitative study with phenomenological approach, was employed to uncover the lived experiences of nephrologists in shared decision making about dialysis initiation.

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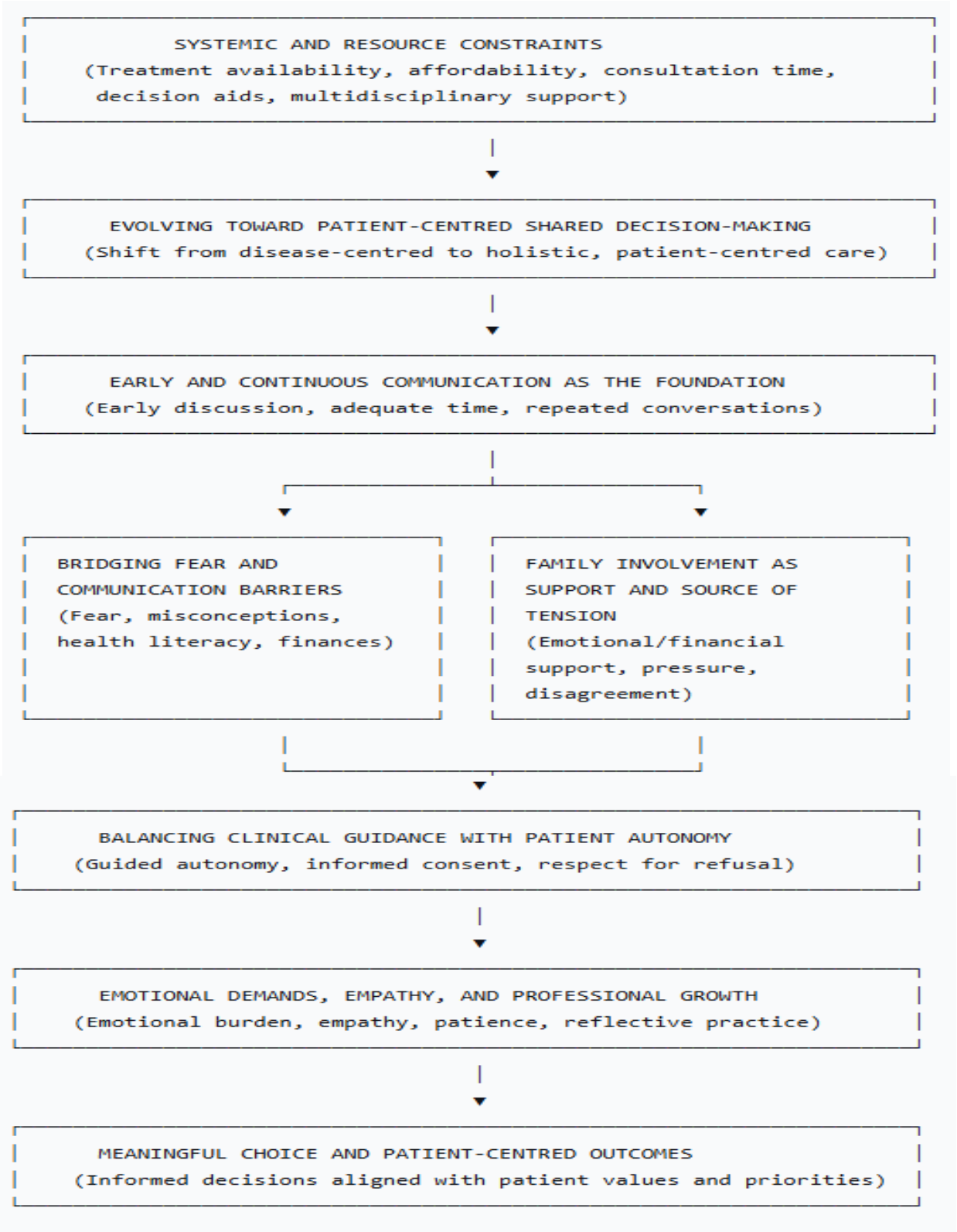


Figure 1. Conceptual Model of the Findings

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The study focused on participants' experiences, perceptions, challenges, emotional responses, and reflections on their clinical practice. A phenomenological orientation was considered appropriate because the study sought to understand how nephrologists attribute meaning to their experiences of dialysis decision-making (Smith et al., 2009). Data were analysed using reflexive thematic analysis (Braun & Clarke, 2006), which allowed for systematic identification and development of patterns across the dataset while remaining grounded in participants' accounts.

Study Setting and Participants

The study was conducted at a tertiary care hospital with nephrology and dialysis services. Consultant nephrologists with direct experience in dialysis decision-making were invited to participate. Purposive sampling was used to recruit participants who could provide rich, relevant information about the phenomenon under study.

Eligible participants were consultant nephrologists or CKD specialist consultants with at least two years of independent nephrology experience who were actively involved in shared decision-making for dialysis initiation. Trainees in nephrology without independent clinical responsibility and physicians not involved in the dialysis decision-making process were excluded.

Five nephrologists participated in the study. Participant characteristics are summarised in Table 1.

Table 1. Characteristics of Study Participants

Participant	Professional Role	Years of Experience	Clinical Setting
P1	Consultant Nephrologist	Several years	Inpatient, outpatient, dialysis, and critical care
P2	Consultant Nephrologist	5–6 years as consultant	CKD, dialysis, AKI, and transplantation
P3	Consultant Nephrologist	6 years	150-bed teaching hospital
P4	Nephrologist	Several years	CKD management, dialysis care, renal replacement therapy
P5	Nephrologist	Not specified	Advanced CKD and renal replacement therapy

Data Collection

Data were collected through individual, in-depth, semi-structured interviews. The interview guide was developed based on the study objectives and existing literature on SDM in nephrology. Interviews explored participants' professional experiences, approaches to discussing dialysis initiation, situations in which SDM was successful or difficult, communication challenges, ethical issues, family involvement, factors influencing patient decisions, emotional experiences, changes in professional practice, and suggestions for improving SDM.

Interviews were conducted in person at a location convenient to participants. Each interview lasted approximately 30–60 minutes. Interviews were audio-recorded with participants' consent and transcribed verbatim. The semi-structured format allowed participants to describe their experiences in their own words and provided opportunities to explore issues that emerged during the interviews.

Data Analysis

Interview data were analyzed using reflexive thematic analysis following the six-phase approach described by Braun and Clarke (2006). The researcher read and reread the transcripts to get to know the data set. Significant statements were found and coded initial statements. The related codes were then compared and categorized into further levels of generalized codes and candidate themes. Coded extracts for each theme were checked for coherence at two levels: a) within each theme, and b) within the

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total set of interviews to make sure that the theme was a pattern over the interviews and not some single statement. Seven final themes were subsequently defined and named. The analysis maintained a distinction between participants' accounts and the researcher's interpretation, while ensuring that the final themes remained grounded in the interview data.

Trustworthiness

Several strategies were used to support the trustworthiness of the findings. Credibility was supported through repeated engagement with the complete dataset and systematic comparison of coded extracts across participants. The final themes were retained only when they demonstrated clear relevance to the research focus and contributed to an integrated understanding of participants' experiences. Reflexivity was maintained throughout the analytical process to acknowledge the researcher's interpretive role. The analysis should be understood as an interpretive account of participants' experiences rather than a claim that all nephrologists experience dialysis decision-making in exactly the same way.

Ethical Considerations

The study received ethical approval from the Institutional Review Board prior to data collection. Participants provided written informed consent before participation. Participation was voluntary, and participants were informed of their right to withdraw at any time without consequence. Interviews were audio-recorded with participants' permission. Transcripts were anonymised, and participants were assigned unique identification codes to protect confidentiality. Data were stored securely and accessed only by the research team.

Results

Five nephrologists participated in the interviews. Their accounts demonstrated substantial convergence regarding the challenges and experiences of shared decision-making for dialysis initiation. Seven themes were identified and are presented below with illustrative quotations.

Theme 1: Evolving Toward Patient-Centred Shared Decision-Making

Participants described a gradual shift from a predominantly disease-centred approach toward a more patient-centred model of practice. As experience grew, nephrologists noted that clinical indications were not enough to make dialysis decisions. A greater number of participants started to look at quality of life, lifestyle, personal priorities, expectations, social circumstances and patient concerns. One of the participants said this is a professional transformation:

"I used to specialise in disease management but now have a more patient-centred approach with shared decision making." (P1)

Another stressed the more global aspect of nephrology practice:

"Through experience I have also learnt that nephrology is not just about medical treatment, but about patient preference and the quality of life." (P2)

Increased focus on listening and understanding what was most important to the patient was linked to this change. Participants explained that they spend more time listening to concerns and then make recommendations; they explained their recommendations in simpler language to help others understand. In my career, earlier I used to listen more to the medical problems behind initiating dialysis, but now I get a better idea of what the patient is concerned about before I get into the specifics of dialysis. (P4) The participants thus had to come to see SDM as something more than a communication skill, but as a clinical practice which emerged by experience and reflection.

Theme 2: Early and Continuous Communication as the Foundation of Decision-Making

It focuses on early and continuous communication as a basis for decisions. One of the most consistent results of the interviews was the early communication. Before a patient "ends up in an emergency situation," all five participants said they stressed talking with them about dialysis. Participants felt that giving patients enough time to discuss the options, have

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questions answered, involve their families as needed, and think through how treatment would impact their lives would be sufficient. “It's easier to talk about dialysis when it's not an emergency.” (P2) Patients should not be first informed about dialysis when in critical and serious condition or need of immediate treatment. (P4) Participants also understood SDM as an ongoing conversation, rather than a single conversation. Sometimes it took sensitive and repeated discussions to make difficult decisions, especially when patients or families were anxious or unsure, or had unrealistic expectations. Shared decision making is a process and not an isolated discussion.

Theme 3: Bridging Fear, Misunderstanding, and Communication Barriers

Fear of dialysis was repeatedly identified as a major barrier. Participants described patients who associated dialysis with dependence, loss of independence, poor quality of life, or a major disruption to daily life.

"Many patients associate dialysis with a permanent loss of independence or a poor quality of life." (P5)

Other barriers included misconceptions, limited health literacy, language difficulties, financial concerns, unrealistic expectations, and difficulty accepting the chronic nature of kidney disease.

"The main challenges are limited health literacy, fear of dialysis, misconceptions about dialysis, financial concerns, and unrealistic expectations." (P3)

Participants responded by adapting their communication. They described using simple and non-technical language, explaining the reasons for dialysis, discussing both benefits and limitations, encouraging questions, and relating medical information to the patient's symptoms and circumstances.

"It is important to identify these concerns and address them individually rather than simply providing medical information." (P5)

The findings suggest that communication during dialysis decision-making involves more than transferring medical knowledge. Nephrologists attempt to bridge the gap between clinical understanding and the patient's perception of dialysis.

Theme 4: Family Involvement as Support and Source of Tension

A strong element in the decision-making process was family involvement. Families were identified as significant sources of emotional, practical and financial support by participants. Family member(s) could help patients with information, treatment options and coping with the effects of dialysis. But family participation may be a hindrance in decision-making. Family members "can provide emotional and practical help, but they also can influence or pressure patients. (P1)" Participants reported scenarios where a family member pressured a patient, dominated patient/family discussion, wanted dialysis to cure the patient and/or voiced wishes not shared by the patient. Family members are a very significant influence and that's especially true in our society. (P3) In the majority of cases, their tastes may differ from the preferences of the patient, however, sometimes their help is needed. (P3) So the nephrologists tried to engage the families in the process, but didn't forget patients' preferences. This was especially significant in the case where the patient was able to make any decisions. "I make sure that the patient's wishes are always at the forefront of the discussion. (P1) Family involvement was thus perceived as twofold, on one hand it could support SDM, on the other it could be a source of conflict between the family intentions and the patient autonomy.

Theme 5: Balancing Clinical Guidance with Patient Autonomy

Participants communicated a constant ethical dilemma when the medical professional has to give advice to the patient, while the patient has the right to make a decision. Scenarios were presented in which patients declined dialysis despite recommendations by nephrologists that it is medically appropriate. Various scenarios were presented that included patients declining dialysis while nephrologists recommended it as medically appropriate. On the other hand, families at times insisted on dialysis when the nephrologist felt that there was little to be gained. Participants did not view respect for autonomy as abdicating professional advice. Rather, they reported a

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process of "guided autonomy." This included providing information about the medical problem, talking with the patient about the benefits and risks, talking with the patient about alternatives, talking with the patient about why they might be refusing, making sure the patient understood the consequences, and respecting a patient with decision making capacity who had informed consent.

"Respecting autonomy does not mean leaving the patient without guidance." (P2)

"I believe my responsibility is to provide clear and honest medical advice without forcing the patient into a particular decision." (P3)

"My role is to explain the expected benefits, risks and alternatives and help the patient make an informed decision rather than making the decision for them." (P5)

Autonomy was therefore understood as an informed and supported process rather than simply allowing patients to make decisions without professional input.

Theme 6: Emotional Demands, Empathy, and Professional Growth

Emotional demands were experienced by the nephrologists in the process of making decisions about dialysis. Specific emotional challenges were reported in relation to young patients, very ill patients, very anxious patients, poor prognosis, significant lifestyle changes and conflicts between the clinical recommendations and patient's wishes. They can be very emotionally upsetting, especially in young patients, very sick patients or anyone who is trying to accept the situation in the family. (P3) Emotional difficulties, however, were not only reported as a negative experience. "These discussions can be emotionally demanding because they involve life-changing decisions. However, they have also made me more empathetic and patient-centred." (P1)

"They can be emotionally demanding... However, these conversations have taught me to remain empathetic and professional and to recognize that the patient's values and priorities are an important part of the decision." (P5)

The experience of difficult conversations encouraged nephrologists to reflect on the importance of patient values and priorities. Consequently, emotionally challenging encounters appeared to contribute to professional development.

Theme 7: Systemic and Resource Constraints Shaping Meaningful Choice

Participants emphasised that SDM occurs within a healthcare system and cannot depend solely on the communication skills of individual clinicians. Limited availability of some treatment options, including peritoneal dialysis and transplantation, was identified as restricting the range of realistic choices.

"Most of the time we're not having access to peritoneal dialysis availability or transplantation as an opportunity for a donor availability. (P2)" Also, financial status, dialysis affordability and accessibility were felt to affect patient decision making. *Accessibility and cost of dialysis is also a very significant concern in our setting. (P3)* The other issues raised by participants were the lack of consultation time, patient education material, decision aids, counselling, communication training and multidisciplinary support. The process could be enhanced by *"patient education materials, good consultation time, multidisciplinary involvement and better counselling for patients and families". (P5)* The results indicated that providing information about theoretical treatment options is not enough to make it meaningful. Patients require practical and practical options, realistic time, a clear explanation, and suitable professional assistance.

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Table 2. Themes, Subthemes and Illustrative Findings

Final Theme	Key Concepts/Subthemes	Illustrative Finding
Evolving toward patient-centred SDM	Patient values, quality of life, active listening, professional development	Shift from disease-centred to patient-centred care
Early and continuous communication	Early discussion, adequate time, repeated conversations	Avoiding emergency decision-making
Bridging fear and communication barriers	Fear, misconceptions, health literacy, language, finances	Adapting communication to patient understanding
Family as support and source of tension	Emotional/financial support, pressure, disagreement	Keeping patient preference central
Balancing clinical guidance with autonomy	Informed consent, refusal, capacity, professional advice	Guided rather than coercive autonomy
Emotional demands and professional growth	Emotional burden, empathy, patience, reflection	Difficult conversations promoting professional growth
Systemic/resource constraints	Treatment availability, affordability, time, decision aids, multidisciplinary care	Meaningful choice depends on healthcare resources

Discussion

This study sought to gain a deeper understanding of the lived experiences of five nephrologists engaged in the shared decision to initiate dialysis. Seven themes emerged that are connected with each other. In summary, findings confirm that dialysis initiation is a complex phenomenon for nephrologists, spanning medical knowledge, communication, patient values, relationships with the family, ethical decision making, emotional experiences, and healthcare-system-related issues. One of the key findings was the shift towards patient-centred practice. Participants reported that they had become more concerned with patients' quality of life, lifestyle, social context, expectations and priorities than with just the nature of the medical indications when discussing dialysis. This indicates that clinical experience may impact on the way nephrologists think about their role in SDM, from one of giving medical advice to one of helping to make informed decisions. The finding is consistent with the general literature on SDM, which highlights the need to combine clinical information with patient values (Elwyn et al., 2012). Another constant was the time of communication. It was noted by all participants that it is important to introduce dialysis in advance of an emergency situation. Early communication was viewed as a way for patients to have time to consider their choices and implications of dialysis. The participants also commented on SDM as a continuous process that needs to be discussed over and over again. This is especially relevant in case the decision changes during disease's progression, when circumstances change or the patients gain a greater knowledge of treatment options. The results of this study support previous qualitative studies that emphasize the need for communication through several cycles and timely delivery in CKD treatment (Tong et al., 2014). Another aspect of the nephrologists' experiences were communication difficulties. The fear and misconceptions about dialysis seemed to be a barrier between the medical knowledge about dialysis and the perceived consequences. Thus, participants used to simplify their explanations and invited questions and discussed their concerns. This means that to communicate effectively is not just about giving more information, it is about providing information that is understandable, relevant and meaningful for the person who is the patient. This result is similar to the studies on patient and caregiver attitudes toward dialysis decision making (Tong et al., 2014). Family involvement was found to be both supportive and problematic. For the family member as described by the participants, this can include emotional and financial support and a

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vital part in healthcare decisions. There can be, however, a conflict between family expectations and patient preferences. The nephrologists then expressed the importance of involving the family without the family's voice being substituted for the patient's voice when the patient has decision-making capacity. In the South Asian culture, where family decisions are not always taken independently of each other, and where the notion of relational autonomy might be more relevant than a more individualistic understanding of autonomy in decision-making, this is especially pertinent. The results also suggest a moral ambiguity in the decision to start dialysis. There was often conflict between clinical recommendations and patient preferences. They tended to be non-coercive, offering clear medical advice. Importantly, participants considered autonomy as supported autonomy: the patient should be given the appropriate professional guidance and given a chance to make an informed decision, knowing the consequences of their decision. This conceptualisation of autonomy is consistent with relational understandings of autonomy in medical ethics. Emotional responses of the nephrologists were an important discovery. Talk about dialysis may be confusing, have a bad outlook, require many changes in lifestyle, and lead to disagreements. However, participants also reported that these experiences led to empathy, patience and professional development. This indicates that SDM can impact both the care of patients and the reflective practice and professional development of clinicians. This aspect of SDM has not been extensively studied in the nephrology literature, and needs to be explored. Last, but not least, the participants noted that systemic factors are relevant to SDM. Patients' ability to make meaningful choices may be limited by limited availability of treatment alternatives, affordability, consultation time, educational resources and multidisciplinary support. Patient autonomy was explicitly mentioned by one participant as being taken away if patient alternatives like peritoneal dialysis or transplantation were not available. The results underscore the need to address organizational and health system-level factors on SDM efforts in nephrology. Combined, these results suggest that SDM cannot be understood as a communication competence that is used in a single consultation. Rather, it is an ongoing process that must start early, involve building relationships, one-to-one communication, respecting families, being sensitive, and offer a healthcare system that can offer realistic treatment options.

Implications for Clinical Practice

The results have some practical implications for nephrology practice. The early onset of dialysis conversation should precede the onset of crisis and should not be delayed until later in the course of advanced CKD. Early conversations give patients and families the time to think about their treatment choices, ask questions and consider how dialysis will impact their life. Secondly, nephrologists must speak simply and clearly and engage patients' fears and expectations, misconceptions and priorities. Communication should be tailored to the individual and not just informative. Third, family members need to be suitably engaged and the wishes of a competent patient need to be at the heart of the matter. This involves being able to manage family dynamics and understand when to involve the family to support rather than hinder the autonomy of the patient. Fourth, clear professional recommendations must not be made at the expense of patient autonomy. The idea of guided autonomy proposed by the participants provides a practical approach to the balance of these responsibilities. Lastly, adequate consultation time, patient education materials, decision aids, communication training, counselling services and multi-disciplinary involvement should support SDM. Organisational support is crucial as SDM is not possible without individual clinician effort.

Strengths and Limitations

Strengths

This study offers a qualitative, in-depth examination of a rarely-studied phenomenon in nephrology: the lived experiences of nephrologists in shared decision-making around dialysis initiation. Semi-structured interviews enabled

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participants to provide rich data on their experiences, concerns and reflections that would not have been obtained using quantitative methods. The analysis process included multiple re-readings of the entire data set, comparative analysis of coded extracts among participants, and coding of thematic statements that reflected common patterns, not just individual statements. The verbatim quotes help persuade the readers of the findings' credibility and enable readers to assess the connection between data and interpretation. There are also a number of clinically actionable themes identified in the study, such as the need for early communication; individualised information; the dual role of family involvement; the ethical dilemma of guidance versus autonomy; and the role of systemic constraints on meaningful choice. The results have implications for the training of communicative competence, the design of communication services and nephrology patient-centred care.

Limitations

Several limitations should be taken into account when interpreting the results. The number of nephrologists included in the study was less than the planned 6–10. While qualitative research is more interested in depth than breadth and small numbers are part of the picture in phenomenological and thematic research, the results are not to be taken as representative of the experience of all nephrologists. Saturation might not have been reached and more interviews may have provided other insights. The study took place in one tertiary care center, potentially reducing the study's transferability to other clinical, cultural, and healthcare-system settings. Themes have been identified, though, which are consistent with the literature reported on SDM in CKD, and thus may be applicable to nephrologists in similar settings. This study was not directly exploring patients or family members' experience but rather the perspective of the clinicians. A more comprehensive understanding of the decision-making process would be gained through future research that included patient and family perspectives. The interviewer was also the researcher, which might have resulted in social desirability bias or an effect on the answers of the participants. The interview guide, however, employed open-ended, non-leading questions, and the participants seemed to feel free to address the challenges and uncertainties openly. Third, the results of the interviews might be applicable in different clinical, cultural, and healthcare-system settings. Most of the families involved in this study have cultural norms that value family decision-making, financial constraints, and some treatment modalities are uncommon. These contextual factors are part of the findings and are important to take into account when applying it to other settings.

Conclusion

The experiences of the nephrologists also show that the decision to initiate dialysis is a multifaceted clinical, ethical, relational, and personal one. The participants spoke about a clear progression towards patient-centred care, with more focus on quality of life, personal priorities and values and social circumstances. Early and ongoing communication was viewed as important and fear, misunderstandings, limited health knowledge, economic issues, family dynamics, and unrealistic expectations were an impediment to decision-making. Nephrologists tried to reconcile their professional advice with their patients' autonomy, and reported having experienced uncomfortable dialogues with patients as a chance to show empathy and develop professionally. Meanwhile, the availability of treatments and costs, the time available for consultation, and the capacity for support services impacted the extent to which meaningful choices could be offered. Shared decision-making for dialysis initiation thus extends beyond clinical knowledge. It needs early communication, listening, information that is understandable, respect for autonomy, engagement that is family sensitive, adequate time, realistic treatment choices and organisational support. These findings help to enhance the understanding of the experience of the nephrologist and provide a foundation for further communication practice,

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clinical training and health care delivery in nephrology.

REFERENCES

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2), 77–101.

Creswell, J. W., & Poth, C. N. (2018). Qualitative inquiry and research design: Choosing among five approaches (4th ed.). SAGE Publications.

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. J. (2012). Shared decision making: A model for clinical practice. Journal of General Internal Medicine, 27 (10), 1361–1367.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. SAGE Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. SAGE Publications.

Tong, A., Cheung, K. L., Nair, S. S., Tamura, M. K., Craig, J. C., & Winkelmayer, W. C. (2014). Thematic synthesis of qualitative studies on patient and caregiver perspectives in chronic kidney disease and dialysis decision-making. American Journal of Kidney Diseases, 64 (4), 559–574.