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A qualitative study of socially isolated patients' perceptions of primary care

Takuya Aoki MD, PhD, MMA[1] | Yuka Urushibara-Miyachi MD, MHPE[2]

[1]Department of Healthcare Epidemiology, School of Public Health in the Graduate School of Medicine, Kyoto University, Kyoto, Japan

[2]Medical Education Center, Graduate School of Medicine, Kyoto University, Kyoto, Japan

Correspondence
Takuya Aoki, Department of Healthcare Epidemiology, School of Public Health in the Graduate School of Medicine, Yoshida-Konoe-cho, Sakyo-ku, Kyoto 606-8501, Japan.
Email: aoki.takuya.26w@kyoto-u.jp

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Abstract

Background: Although the previous quantitative study revealed that social isolation was negatively associated with patient experience of primary care, the underlying reasons for this phenomenon remain unclear. In the present study, we aimed to explore the reasons underlying the influence of social isolation on patient experience in the primary care setting.

Methods: This study was a qualitative study and part of a mixed methods research. Semistructured telephone interviews were performed. We recruited participants among eligible participants in the previous quantitative survey who were classified as being socially isolated. Data were transcribed verbatim and analyzed thematically by two independent researchers until saturation was reached.

Results: Eight socially isolated patients in the research were interviewed. In the thematic analysis, three major themes emerged as reasons underlying the influence of social isolation on patient experience of primary care: restriction of information about local primary care physicians, finding a usual primary care physician haphazardly, and superficial relationship with a usual primary care physician.

Conclusions: This study identified three major themes, which are beneficial to expand our understanding of socially isolated patients' perceptions of primary care. These findings can be used to improve patient experience of primary care in socially isolated patients.

KEYWORDS

patient experience, primary care/general practice, social isolation

1 | INTRODUCTION

Social isolation is a major health problem for older adults and are associated with numerous negative health outcomes, such as increased risk of all-cause mortality,[1,2] mortality from coronary heart disease/stroke,[3] rehospitalization,[4] falls,[5] cognitive decline,[6] and death from suicide.[2] Social isolation is defined as a state in which an individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts, and displays a deficiency in fulfilling quality relationships.[7]

For clear understanding of the relationship between social isolation and health outcomes, patient experience may be one of the important concepts. Patient experience is defined as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions, across the continuum of care.[8] Patient experience is considered the most effective quality measure of

patient-centeredness, which is defined as providing care that is respectful of and responsive to patient preferences, needs, and values.[9] Patient experience is known to affect positively health outcomes through patient behaviors, such as adherence to treatment and healthcare resource use.[10,11]

Previous studies have shown demographic and socioeconomic variations in patient experience.[12–15] A qualitative study has reported the suffering experienced by those who are socially isolated and lack the knowledge, skills, physical well-being, and support to access relevant health services.[16] In another study, social isolation has been identified as an unmet need in elderly primary care patients;[17] however, the challenges regarding primary care attributes other than accessibility experienced by socially isolated patients remain unclear.

The aims of these studies using a mixed methods research design were to examine the influence of social isolation on patient experience and to explore the underlying reasons for this influence in elderly primary care patients. Our previous quantitative study revealed that social isolation was negatively associated with patient experience of primary care attributes, especially regarding longitudinality, comprehensiveness, and community orientation[18]: longitudinality—long-term personal relationship between practitioners and patients; comprehensiveness—availability and provision of services to meet all but uncommon population needs; community orientation—provision of care to a defined community on the basis of its assessed health needs through the integration of public health practice with primary care services.[19]

Following the quantitative study, we conducted this qualitative study to expand our understanding of the influence of social isolation on patient experience to reasons underlying this phenomenon. These findings may be useful to improve patient experience of primary care in socially isolated patients.

2 | MATERIALS AND METHODS

This study was a qualitative study and part of a mixed methods research. We used an explanatory sequential mixed methods research design[20] using a structured survey among elderly primary care patients followed by semistructured telephone interviews with socially isolated elderly patients. First, the quantitative cross-sectional survey was conducted in a primary care practice-based research network (PBRN) in Japan from October 2015 to February 2016. The PBRN where this study was conducted is part of a national network of primary care clinics belonging to the Japanese Health and Welfare Co-operative Federation and the Japan Federation of Democratic Medical Institutions. The 28 participating clinics were distributed in both urban and rural areas, and primary care in these clinics is delivered by family physicians. We collected data on social isolation, patient experience of primary care, and patient demographics from outpatients aged ≥ 65 years who visited one of the participating clinics. The detailed methods of the quantitative survey were reported in our previous study.[18]

2.1 | Design and participants

In this qualitative study, we have explored perceptions of primary care in socially isolated patients through individual interviews based on constructivism. Following the quantitative survey, we conducted semistructured qualitative telephone interviews of socially isolated elderly patients. We used the Japanese version of the abbreviated Lubben Social Network Scale (LSNS-6)[21,22] to evaluate the social isolation in elderly individuals (Table S1). This tool assesses the size, closeness, and frequency of contacts in a respondent's social network. The scores range from 0 to 30 points, with higher scores indicating a better quality of social network. We classified patients with a score of <12 points as being socially isolated. Among 127 elderly patients who were classified as being socially isolated in the previous quantitative survey, we sent formal recruitment mails to 24 patients who indicated a willingness to participate in further qualitative research from February 2017 to March 2017. Among them, eight socially isolated elderly patients in the research agreed and participated in telephone interviews.

2.2 | Data collection

A study investigator (TA) interviewed participants by telephone using a semistructured interview guide containing open-ended questions (Table S2). This guide was developed in part on the basis of the results of the quantitative survey. For example, the survey result indicated that socially isolated elderly patients had negative patient experience of community orientation. Thus, the interview guide was designed to understand how and why social isolation affects experience of community orientation. In the interview, we used the Japanese term “Kakaritsukei” which generally means primary care physician and is familiar with the participants. Interviews were 30-45 minutes in length. All interviews were audiotaped and transcribed by a member of the research team. The participants received $30 gift certificates. The interview transcripts were not returned to the participants for comment and correction.

2.3 | Analysis

The method of thematic analysis described by Braun and Clarke[23] was used to analyze the data, using Starfield's primary care attributes[19] as an analytic framework. The data were independently reviewed by a researcher (TA) and a member of the team that was not involved in the interviewing process (YM). Each reviewer independently identified codes and themes that described how or explained why social isolation affects patient experience of primary care until saturation was reached. The reviewers (TA and YM) held discussions to agree upon the development of codes and themes. The participants did not provide feedback on our research findings.

2.4 | Research team and reflexivity

TA is a MD and a PhD candidate in the School of Public Health performing both quantitative and qualitative studies and has experience

TABLE 1 Characteristics of the eight patients with social isolation interviewed for the study: N (%)

Characteristic	
Gender	
Male	4 (50.0)
Female	4 (50.0)
Age (year)	
65–69	3 (37.5)
70–79	5 (62.5)
80 or more	0 (0.0)
Education	
Less than high school	3 (37.5)
High school	1 (12.5)
Junior college	2 (25.0)
More than or equal to college	2 (25.0)
Annual household income (million JPY)	
<2.00 (≒18 000 US dollar)	2 (25.0)
2.00-4.99	5 (62.5)
≥5.00	1 (12.5)
Number of comorbidities[a]	
0	2 (25.0)
1	4 (50.0)
≥2	2 (25.0)

[a]Simple counts of the following chronic conditions: hypertension, diabetes, dyslipidemia, stroke, cardiac diseases, chronic respiratory diseases, digestive diseases, kidney diseases, urologic diseases, arthritis, rheumatism, mental disorders, endocrine diseases, and malignancy.

with research on patient experience in primary care. YM is a MD and has a Master of Health Professions Education. She is an assistant professor in the Medical Education Center and performing qualitative studies.

No relationship with the participants was established before the commencement of the study. The participants knew that the interviewer was a clinical researcher in the School of Public Health performing research about the quality of primary care.

2.5 | Ethics

The ethical committee of the Kyoto University Graduate School of Medicine provided ethical approval for this study (approval number R0184). Written informed consent was obtained from all study participants.

3 | RESULTS

The characteristics of the interview participants are shown in Table 1. The interviewed participants varied in terms of sex and socioeconomic status. In the thematic analysis, three major themes emerged as reasons underlying the influence of social isolation on patient experience of primary care: restriction of information about local primary care physicians, finding a usual primary care physician haphazardly, and superficial relationship with a usual primary care physician.

3.1 | Restriction of information about local primary care physicians

Most commonly reported, socially isolated patients in the research described the restricted availability of information regarding local primary care physicians. All participants were concerned regarding the restriction of the opportunity to obtain information regarding local primary care physicians from the community members, such as acquaintances and friends.

> When I found my primary care physician, I never heard doctor's reputation from someone like acquaintance.

> No one will talk about my primary care physician. I do not have a friend who attends the clinic there.

Most participants had fewer opportunities to perceive or participate in community activities involving local primary care physicians, such as health festivals.

> I do not know how much my primary care physician is involved in community activities.

> I have not participated, but it seems that my primary care physician is doing events with the local people in the clinic parking lot.

3.2 | Finding a usual primary care physician haphazardly

Most socially isolated patients in the research had experience in identifying a usual primary care physician haphazardly. Participants showed a tendency to consult primary care physicians experimentally without sufficient information from community members, and a few patients had an experience of the failed experiment.

> Try going to a nearby clinic and if I like it, I decide it as my primary care provider for the time being.

> I examined a medical institution on the Internet and I visited, but it was disappointing.

In addition, the participants expressed the choice of usual primary care physician as a passive action rather than an active action.

> I go to the reception of a medical institution, and it is just like being assigned to the doctor.

> The doctor of the clinic where I went by chance will become my primary care physician.

3.3 | Superficial relationship with a usual primary care physician

Socially isolated patients in the research expressed having superficial relationships with their usual primary care physician. Some participants had restricted the role of their primary care physician to prescribing medications and small talk.

> In my case, I only have a doctor to see a chronic illness, so I will not talk with my primary care physician so much.

> I only ask my primary care doctor to prescribe medications and have a chat.

They also expressed resistance to sharing social information, including their family context and advance care planning, with their usual primary care physician.

> I will never speak with my primary care physician about things related to my family.

> I want to talk about my wishes for future medical care, if I could feel reliance on the clinic and the primary care doctor in the future.

4 | DISCUSSION

In our qualitative analysis, socially isolated patients reported a lack of informational support in identifying a usual primary care physician and superficial relationships with the primary care physician. In addition, patients were reluctant to select the right primary care physician to suit them. The present study indicated that worse patient experience in socially isolated patients is caused by bidirectional problems, not a one-way problem of limiting information provision about local primary care physicians for isolated patients. Because there is a possibility that isolated patients' active behavior restricting the role of primary care physicians to only medical problems and not providing social information about themselves to the physicians also negatively affects the structure of patient experience in isolated patients. Combining the previous quantitative results[18] and the present qualitative results, we infer that the lack of participation of the socially isolated patients in community activities by primary care physicians negatively affects their experience of community-oriented primary care. Similarly, limiting the role of primary care physicians and patient resistance to the sharing of social information as their potential needs might negatively affect patient experience of longitudinality and comprehensiveness.

Our previous quantitative study identified longitudinality, comprehensiveness, and community orientation as unmet needs in socially isolated elderly patients in primary care.[18] The results of the present qualitative study have contributed additional findings regarding the potential reasons by which social isolation influences patient experience. Our findings are in agreement with previous study results regarding the needs of isolated older patients. A previous quantitative study showed that most older primary care patients wanted the services receiving information about health services or community resources.[24] According to the previous qualitative studies, isolated older patients expressed not only a sense of loneliness but also a sense of not being met with needs and being treated without empathy in relation to healthcare providers.[25,26] On the other hand, another qualitative study exploring healthcare providers' perceptions in the provision of care to isolated old patients showed that providers experience significant levels of concern in building interpersonal relations between provider and isolated patient because of time pressure and organizational and professional rules.[27] These findings suggest that both patient factor and provider factor may be involved in the reasons for the influence of social isolation on patient experience.

To the best of our knowledge, this is the first detailed investigation to explore reasons underlying the influence of social isolation on patient experience in the primary care setting. A mixed methods research design enabled us to select study participants based on an established measure for the evaluation of social isolation used in the quantitative survey. In the analysis process, we used investigator triangulation to develop a comprehensive understanding of phenomena.

Our study has several limitations. First, the subjects of this study were socially isolated patients; thus, the sample size was relatively small and there was the possibility of insufficient maximum-variation sampling due to recruitment difficulty. However, we considered that thematic saturation was reached after analyzing the eight interview transcripts. Second, we collected and analyzed the qualitative data to help explain the previous quantitative findings based on an explanatory sequential mixed methods research design. Thus, the authors' recognitions about the former quantitative results might affect the results of this qualitative study excessively. However, we used investigator triangulation to minimize the influence of researchers' biases. Third, in this study, we were not able to obtain sufficient data on the causes of the superficial relationship between socially isolated patients and their usual primary care physician; hence, further studies are needed. Fourth, our study setting was restricted to primary care clinics that had a known interest in healthcare quality. In addition, our study participants were restricted to socially isolated patients who have a usual primary care physician. Therefore, the transferability of our findings to other populations is not known.

5 | CONCLUSIONS

This study identified three major themes, which are beneficial to expand our understanding of socially isolated patients' perceptions of

primary care. These findings can be used to improve patient experience of primary care in socially isolated patients.

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CONFLICT OF INTEREST

The authors have stated explicitly that there are no conflicts of interest in connection with this article.

ORCID

Takuya Aoki https://orcid.org/0000-0002-8232-2155

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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