Patient Expectancy of Shared Decision Making according to Ego States in Primary Care

Birinci Basamakta Ego Durumlarına Göre Hastanın Ortak Karar Verme Beklentisi

Ⓘ Genco Görgü[1], Ⓘ Vildan Mevsim[2]

[1]Bandırma 1st Family Medicine Center, Marmara District State Hospital Family Medicine Department, Balıkesir, Türkiye
[2]Dokuz Eylül University Faculty of Medicine, Department of Family Medicine, İzmir, Türkiye

ABSTRACT

Objective: Shared decision-making (SDM) is a clinical approach that involves presenting options to the patient, providing comprehensive information about these options, and actively engaging in the decision-making process. The objective of this study was to investigate patients' SDM expectations within the realm of primary healthcare, focusing on the correlation with their ego states.

Methods: A cross-sectional study was conducted, involving a sample size of 402 patients, determined on the basis of a 50% prevalence rate, 95% confidence level, and 0.05 margin of error. The "Primary Care Patients' Expectancy for Shared Decision Making Questionnaire," the Ego States scale, and a demographic data form were administered to the participants. Data analysis was performed using the IBM SPSS Statistics 22.0 software package. Statistical analysis included descriptive measures (mean, standard deviation, and percentage), chi-square analysis, and logistic regression.

Results: There exists no significant statistical relationship between patients' ego states and their expectations of shared decision making (p=0.567). However, patients' age (p=0.020), presence of a chronic disease (p=0.010), presence of a psychiatric disorder (p=0.006), and educational status (p=0.039) demonstrated a significant impact on patient expectations concerning shared decision making. According to the results of the logistic regression analysis, the presence of a chronic disease increases the expectancy for shared decision making by a factor of 3,931 compared with patients without the disease. Conversely, individuals with a history of psychiatric illness showed a 3,573-fold increase in the expectation of shared decision making. Furthermore, for those residing with 3 or more individuals in the same household, the anticipation of shared decision making rises by 2,224 times compared to those living with 2 or fewer individuals.

ÖZ

Amaç: Ortak karar verme (OKV), hastaya mevcut seçeneklerin sunulması, bu seçenekler hakkında detaylı bilginin verilmesi ve karar verme sürecine hastanın aktif katılımını kapsayan bir klinik yaklaşımdır. Bu çalışmanın amacı birinci basamakta sağlık hizmeti alma sürecindeki hastaların ego durumlarına göre OKV beklentilerinin incelenmesidir.

Yöntemler: Likert tipi 32 sorudan oluşan "Birinci Basamakta Hasta OKV Beklentisi Veri Formu" oluşturulmuştur (Keiser-Meyer-Olkin 0,986, Cronbach alfa 0,98). İkinci aşamayı teşkil eden kesitsel analitik araştırmada; %50 prevalans, %95 güven düzeyi ve 0,05 hata payı ile belirlenen 402 kişilik örnekleme dahil edilen hastalara, "Birinci Basamakta Hasta OKV Beklentisi Veri Formu", Ego Durumları Ölçeği ve Demografik Veri Formu uygulanmıştır. Verilerin değerlendirilmesi amacıyla; tanımlayıcı analizler, ki-kare analizi gerçekleştirilmiş ve lojistik regresyon modeli oluşturulmuştur.

Bulgular: Birinci basamakta sağlık hizmeti alan hastaların ego durumları ve OKV beklentileri arasında anlamlı bir istatistiksel ilişki ortaya konamamıştır (p=0,567). Katılımcılara ait yaş (p=0,020), kronik hastalık (0,010), kronik hastalık (0,010) ve eğitimi durumu (p=0,039) gibi özelliklerin, OKV beklentisi üzerinde anlamlı etkisi olduğu ortaya konmuştur. Lojistik regresyon analizi bulgularına göre, kişinin kronik hastalığının olması, olmayanlara göre OKV beklentisini 3,931 kat artırmaktadır. Bunun yanında, kişinin psikiyatrik hastalık öyküsüne sahip olması ise OKV beklentisini 3,573 kat artırmaktadır. Aynı evde 3 ve üzeri kişi ile yaşayanlarda OKV beklentisi 2 ve 2'den az kişi ile yaşayanlara göre 2,224 kat artmıştır.

Sonuç: Birinci basamakta hastaların OKV beklentisinin, hastaların sosyodemografik özellikleri ile değişmekte olduğu saptanmıştır. OKV ve psikolojik fenomenler arasındaki ilişkinin anlaşılabilmesi için yeni araştırmalara ihtiyaç duyulmaktadır.

Address for Correspondence/Yazışma Adresi: Genco Görgü, MD, Bandırma 1st Family Medicine Center, Marmara District State Hospital Family Medicine Department, Balıkesir, Türkiye
E-mail / E posta: ggorgu@gmail.com
ORCID ID: orcid.org/0000-0002-5420-0230

Conclusion: Significantly, the ego states of patients accessing primary care services do not substantially impact SDM expectations. Based on the findings of this study, it is essential to acknowledge that SDM expectations among primary care patients are influenced by their sociodemographic characteristics. Furthermore, further research is warranted to understand the influence of psychological factors on SDM.

Keywords: Shared decision making, primary care, ego states, patient centered care, interpersonal skills, family medicine

INTRODUCTION

Family medicine is a distinct medical discipline characterized by specialized education, practice, and research, predominantly situated within the realm of primary health care. To underscore the professional qualifications of family physicians who are experts in this field, the fundamental competencies of family medicine have been outlined. Among the six key competences, "person-centered care" stands out. Within this domain, shared decision making is one of the four subcomponents. Shared decision-making (SDM) refers to the clinical process in which both the patient and the physician collaboratively agree on a treatment or course of action. This consensus is forged through a mutual understanding of knowledge, values, and priorities (1).

Establishing a robust patient- physician relationship is crucial for facilitating the SDM process. This relationship entails transparently conveying the patient's medical condition, encouraging open discussions about potential scenarios, and eliciting the patient's unique perspective in the decision-making process. To facilitate effective communication, Berne's Transactional Analysis approach provides valuable guidance. According to this framework, individuals engage with their environment through three distinct ego states: Parent, adult, and child (2).

The parent ego state involves setting boundaries, giving directives, and exerting control. The adult ego state operates within a rational framework, sharing knowledge and priorities. The child ego state emphasizes creativity, intuition, and enjoyment. To foster a patient-physician relationship that respects individual autonomy, it would be advantageous to explore the impact of psychological factors such as ego states within the context of primary care. Embracing shared decision making as a clinical methodology can enhance this dynamic (2).

Despite the recognized importance of SDM (3), its implementation in primary care remains limited (4). Factors such as time constraints, lack of physician knowledge, and resistance to change hinder its widespread adoption (5) and cultural differences (6,7). Investigating the influence of psychological factors such as ego states in the SDM process within the primary care setting presents a unique avenue for enhancing patient-centered care. By understanding how different ego states may influence patients' preferences, levels of engagement, and perceived control over medical decisions, healthcare providers can tailor their communication strategies to better accommodate individual psychological needs.

This study aims to fill a significant gap in the existing literature by investigating the interplay between ego states and SDM in primary care. By exploring how ego states manifest during patient- physician interactions and influence decision-making dynamics, these research endeavors to shed light on the psychological underpinnings that shape medical decisions. The insights gained from this study can offer practical implications for healthcare professionals, aiding them in crafting more effective communication strategies that align with patients' psychological orientations. Ultimately, the findings can bridge the gap between patient expectations, physician practices, and the SDM process, thereby fostering improved patient outcomes and healthcare experiences.

The objective of this study was to investigate patients' SDM expectations within the realm of primary healthcare, focusing on the correlation with their ego states.

MATERIALS AND METHODS

The study was conducted using a cross-sectional analytical model. The study received ethical approval from the Dokuz Eylül University Non-invasive Ethics Committee (approval number: 2020/03-37, date: 03.02.2020), and informed consent was obtained from all participants.

Population and Sampling

The study was carried out in 6 Training Family Health Centers affiliated with Dokuz Eylül University. Individuals aged 18 and above who applied to the Dokuz Eylül University Training Family Health Centers (DEU-EASM) and agreed to participate were included in the study. The exclusion criteria encompassed those with an inability to communicate clearly in Turkish and individuals with mental conditions that adversely affect their perception of reality (e.g., psychosis, dementia). The target was to reach a minimum of 387 participants with a prevalence of 50%, a margin of error of 0.05, and a confidence level of 95%; the study was completed with 402 participants. The convenience sampling method was chosen as the sampling technique.

Data Collection Method and Instruments

Data were collected through face-to-face interviews using a questionnaire. The data collection tools included a sociodemographic data form, the "Patient Expectancy of SDM Data Form," and the "Ego State Scale."

Sociodemographic Data Form

The data collection form comprises 15 questions designed to gather patients' demographic information, including gender, history of chronic diseases, educational level, employment status, marital status, family composition, number of cohabitants, and duration of residence at their current address.

Ego State Scale

The "Ego State Scale," developed by Ozpolat (8) in 2015, is used as an assessment tool for the sampled patients. This scale encompasses three sub-dimensions (parent, adult, child) and comprises 17 items.

The Ego State Scale employs a Likert-type format, with participants indicating the degree of resonance with each item on a scale of 1 to 5. The response options are as follows: "5= strongly like me," "4= like me," "3= neutral," "2= not like me," and "1= strongly not like me."

The scale consists of three sub-dimensions: parent ego state (7 items), adult ego state (4 items), and child ego state (6 items). The standard response time for the scale, which is suitable for both individual and group administration, is set at 5 min. Within the Ego State Scale, an individual's "ego state" is determined on the basis of the subscale in which they attain the highest score.

Patient Expectancy of the Shared Decision Making Data Form

The development of the PESDM form was performed by the researchers involved in this study before this cross-sectional research. A validity and reliability study was conducted to establish the PESDM form. The items for the form were collected through focus group interviews and one-on-one discussions. Participants for these discussions were volunteers aged 18 years and above who applied to DEU-EASM. We employed a maximum diversity sampling method. For this study, we conducted two focus group discussions (with 6-12 participants each) and two individual in-depth interviews, involving a total of 20 participants (9). Using semi-structured interview questions, we gathered the opinions and sentiments of patients regarding shared decision making. The discussions were audio recorded, and data were collected in this manner. Subsequently, transcription of the recordings was performed, followed by analysis. Descriptive analyses were employed to analyze the interviews. The two researchers involved in the study conducted and transcribed the interviews separately. Audio recordings were transcribed, and on the basis of the transcriptions, opinions expressed by the patients were categorized within the context of SDM literature. The researchers categorized diverse viewpoints into items and later, through consensus sessions, finalized these items. This led to the formation of the 50-item measurement tool.

Upon finalization, the PESDM form was administered to a cohort of 320 individuals receiving services from 6 DEU Educational Family Medicine Units. This process assessed the form's validity and reliability. Participants were requested to express their alignment with each item using a 5-point Likert scale ranging from 1 to 5. The response options were graded as follows: 5= strongly agree, 4= agree, 3= undecided, 2= disagree, and 1= strongly disagree.

Post-analysis, the form was refined to encompass 32 items and designated the "Patient Expectancy of SDM Data Form." The Cronbach's alpha coefficient for the overall scale yielded a value of 0.98, signifying robust internal consistency (Table 1). To explore the factor structure, Principal Components Analysis an exploratory factor analysis method, was employed. An adequate sample size is pivotal for effective factor analysis (10). The Kaiser-Meyer-Olkin coefficient, which assesses sample adequacy, was determined to be 0.986 in this study, indicating exceptional suitability for factor analysis within the participant sample of 320 (10).

The Bartlett test, evaluating the data's adherence to a multivariate normal distribution, yielded a highly significant result (χ^2=3022.014, p=0.000), affirming the data's appropriateness for factor analysis. The factor analysis marked the culmination of validity studies, resulting in a refined 32-item data form based on a 5-point Likert scale. The total score of the PESDM form was obtained by summing the scores of all 32 items. The minimum score that can be obtained from the PESDM form is 32, and the maximum score is 160. The cut-off score was determined to be 97 by the parametric method. Those below this value were defined as low, and those with a score of 97 and above were defined as having high SDM expectation. Analysis was performed using IBM SPSS Statistics 22. The statistical findings endorsed the validity and reliability of the PESDM form.

Statistical Analysis

In our cross-sectional study, data analysis was performed using IBM SPSS Statistics 22 software. The data analysis process involved descriptive statistics, t-tests for continuous variables, and chi-square analysis for categorical variables. Furthermore, logistic regression analysis was conducted using a model that incorporated the independent variables influencing ego states.

RESULTS

The study included 402 patients who sought services at the Dokuz Eylül University Education Family Health Centers in February 2020. The average age of the participants was 32.63±14.39 years. Among the 402 participants, 60.4% were women and 44.8% were married.

Regarding employment status, 31.6% of the participants were currently employed, while 68.4% were not working. Of the unemployed participants, 23.6% were housewives, 14.0% were retired, and 62.4% were students. In terms of economic status, 26.4% of the patients described it as good, 64.7% as moderate, and 8.9% as poor.

Table 1. Distribution of shared decision-making expectations according to participants' ego states

Ego state	Total	SDM	Expectation	p
	n	Low, (%)	High, (%)	
Adult	160	19.4	80.6	
Parent	125	16.8	83.2	
Child	117	22.2	77.8	0.567
Total	402	19.4	80.6	

SDM: Shared decision-making.

A total of 26.6% of the participants were born in İzmir, and 46.5% had been residing in İzmir for more than 10 years. Family structure analysis revealed that 81.3% of the participants belonged to nuclear families, with the majority (68.6%) residing in households with 3-5 occupants. Regarding health conditions, 22.4% of the participants had chronic diseases and 8% had been diagnosed with psychiatric disorders.

Evaluating participants' ego state distribution, 39.8% were classified as adults, 31.1% as parents, and 29.1% as children. In terms of SDM expectations, 19.4% of the participants had low-level expectations, while 80.6% had high-level expectations. The mean score on the Patient Expectancy of SDM Data Form was 137.3±11.4.

While examining the anticipation of shared decision making based on participants' ego states, it was observed that 83.2% of individuals with a parent ego state, 80.6% of those with an adult ego state, and 77.8% of those with a child ego state had high expectations for SDM. Nevertheless, the observed variations did not show statistically significant differences (p=0.567) (Table 1).

When considering the expectation of making shared decisions based on participants' birthplace, notably 87.9% of participants born in

İzmir exhibited a high SDM expectation. In contrast, this percentage was 78% for participants born outside İzmir (p=0.027) (Table 2).

Examining participants' expectations of making shared decisions based on the number of people living in the same household, it is evident that the group with the highest rate of high SDM expectation consisted of those with 3-5 people residing in the same household (84.8%). Conversely, those living with 2 or fewer individuals in the same household displayed 70.2% lower SDM expectations (p=0.006) (Table 2).

When evaluating the participants' SDM expectations in relation to their duration of residence in their current city, a substantial contrast emerges. While 86.6% of participants who have resided in İzmir for over 10 years held a high SDM expectation, those who have lived between 1 and 5 years exhibited a lower SDM expectation (72.3%) (p=0.014) (Table 2).

Furthermore, this study revealed a significant association between participants' SDM expectations and certain health conditions. Specifically, participants with chronic diseases demonstrated a higher SDM expectation (90.0%) (p=0.010), whereas those with psychiatric illnesses exhibited a lower SDM expectation (71.9%) (p=0.006) (Table 3).

Table 2. Evaluation of shared decision-making expectation levels based on selected participant characteristics

Characteristics	Total	SDM	Expectation	p
	n	Low, (%)	High, (%)	
Birth place				
İzmir	107	12.1	87.9	
Other	295	22.0	78.0	**0.027**
Residence time				
Less than a year	43	23.3	76.7	
1-5 years	130	27.7	72.3	
5-10 years	42	16.7	83.3	**0.014**
More than 10 years	187	13.4	86.6	
Cohabitants				
2 and fewer people	94	29.8	70.2	
3-5 people	276	15.2	84.8	**0.006**
6 or more people	32	25.0	75.0	
Total	402	19.4	80.6	

SDM: Shared decision-making.

Table 3. Evaluation of participants' expectation levels of shared decision making according to their medical conditions

Clinical status	Total	SDM	Expectation	p
	n	Low, (%)	High, (%)	
Chronic disease				
Yes	32	10.0	90.0	
No	370	22.1	77.9	**0.010**
Psychiatric disease				
Yes	32	28.1	71.9	
No	370	18.6	81.4	**0.006**
Total	402	19.4	80.6	

SDM: Shared decision-making.

A logistic regression model was used to assess the impact of independent variables on SDM expectations. The results revealed that having a chronic disease increased the SDM expectation by 3.93 times [confidence interval (CI): 1,712-9,026] compared with those without a chronic disease. Similarly, a history of psychiatric illness was associated with a 3.57 times increase in SDM expectation (CI: 1,606-7,951). Furthermore, individuals living with 3 or more people in the same household exhibited a 2.22 times higher SDM expectation (CI: 1,269-3,895) than those living with 2 or fewer people (Figure 1).

DISCUSSION

The primary aim of this study was to explore patients' expectations regarding shared decision making in primary care, with a focus on their ego states. In this context, data from 402 participants receiving primary care services were analyzed. Among the participants, a significant proportion were women and a notable number were married. Some participants were born in İzmir while many had established long-term residence there. The majority came from nuclear families, often residing in households with 3-5 occupants. Certain participants had chronic illnesses, and a smaller subset had been diagnosed with psychiatric disorders.

The rate of participants with a high expectation of shared decision making in our study was 80.6%. In a study by Sekimoto et al. (11), the rate of patients who "make a participatory decision" was found to be 75%. Cofield et al. (12) reported that 90.7% of participants preferred the patient-centered approach and the principle of shared decision making. It is evident that the findings of our study align with results in the international literature. Our study stands apart from similar research that uses images, vignettes, and patient-centered approach scales symbolizing the patient- physician relationship because of our use of a measurement tool specifically designed for shared decision-making.

Participants born in İzmir, the province where the research was conducted, demonstrated a higher expectation of shared decision-making. Similar findings were noted by Hawley and Morris (7) in a study involving US-born participants, who exhibited greater involvement in the SDM process. When facing the physician, who holds a dominant role in the patient- physician relationship with their white coat and professional title, it is plausible that a patient with the confidence of being a "local" might feel empowered to bridge the gap with the authoritative image they are interacting with, thus inviting them to a common ground.

Furthermore, our study revealed that participants who had resided in İzmir for an extended period also displayed a heightened expectation of SDM. Existing literature indicates that cultural norms within a given region can shape interpersonal dynamics. Drewelow et al. (13) study involving patients with type 2 diabetes mellitus in primary care found that patients residing in Mecklenburg-West Pomerania were more likely to engage in SDM compared with patients in North Rhine-Westphalia. The primary care setting reflects the social context and interpersonal relationships of a specific region because of its physical location, and its patient population is largely representative of the broader population (13). Suurmond and Seeleman (14) identified migration as a potential barrier to achieving shared decision making, highlighting how individuals who gradually integrate into their living environment over time tend to possess greater confidence in voicing their opinions within their doctor- patient relationship.

A significant result from our study was that 90% of individuals with chronic diseases exhibited a high expectation of SDM. This trend aligns with the outcomes of the logistic regression model, which highlighted the association between having a chronic disease and an increased SDM expectation. Tom et al. (15) similarly observed that 83% of patients with chronic illnesses engaged in a participatory approach to clinical decision-making. Advancements in information and communication technology cater to patients' pursuit of health literacy, although they might occasionally encounter unfiltered or erroneous information. This phenomenon reduces the occurrence of the dismissive phrase "you know." Patients who perceive themselves as well-informed are inclined to explore all available options and potentialities (16). In a cross-sectional analytical study by Peek et al. (17) involving adult patients diagnosed with hypertension under primary care in the USA, it was noted that the propensity for SDM between patients and physicians grew as the burden of chronic illness intensified and self-care became necessary for managing the condition.

Another noteworthy outcome of our analysis was a lower SDM expectation among patients diagnosed with psychiatric illnesses.
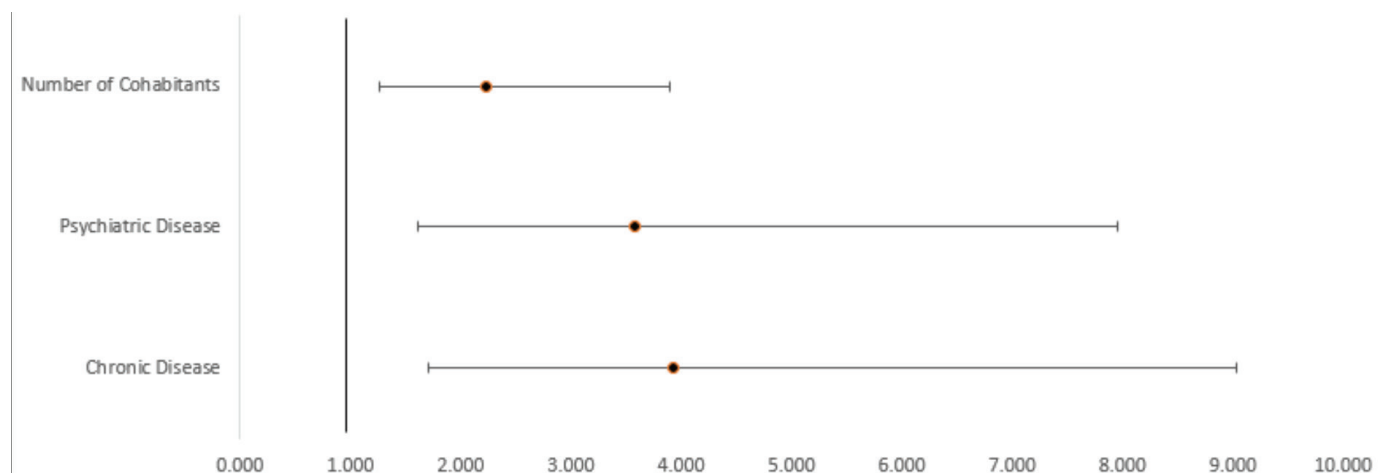

Figure 1. Logistic regression analysis results for the impact of independent variables on shared decision-making expectations.

In De las Cuevas' (18) study, which investigated the priorities of outpatient psychiatric patients diagnosed with affective disorders regarding involvement in shared decision-making, patients expressed a desire for information about their clinical status and available treatment options. However, they predominantly favored a passive role and considered it appropriate to adhere to the psychiatrist's authority (18).

Conversely, our study did not reveal a significant relationship between Ego State and SDM expectation. Research on the interplay between ego states and decision-making processes within the framework of Transactional Analysis is limited in the existing literature. According to the Freudian approach, the ego or self constitutes a fundamental aspect of one's personality. Braman and Gomez (19) study investigating the influence of patient personality traits on patient-physician relationships found no correlation between personality traits and active participation in medical decisions.

Exploration of psychological theories within the context of primary care clinical settings and patient- physician relationships remains a relatively unexplored research domain. The ego (self) serves as the nucleus of an individual's biopsychosocial identity. Watkins, a pioneer in Ego State Therapy, emphasizes the role of the "important introjected other" in shaping ego states. Berne posits that every individual possesses three ego states-adult, child, and parent. While the ego state, a structured system of behaviors and experiences, is conventionally perceived as stable, its boundaries are fluid. The literature introduces the concept of "Dynamic Ego States," underscoring that personality evolves with ongoing vitality, rather than being static. The dominant ego state emerges by interconnecting suitable personality segments depending on the context and circumstances. The continuous nature of the patient–physician relationship in primary care clinics means that a patient's ego state can fluctuate due to fresh experiences, the expression of ingrained emotions, and interactions with the physician. Consequently, establishing a linear relationship between patients' SDM expectations in primary care and a specific ego state may not be feasible (20).

Strengths and limitations

This study demonstrates numerous strengths. Its originality lies in its distinctive approach of investigating patients' SDM expectations in primary care according to their ego states. This innovative perspective has the potential to provide fresh insights and contribute to the existing literature. Moreover, the study boasts several other commendable strengths that bolster its rigor and significance. The use of a specialized measurement tool tailored for assessing SDM expectations ensures a meticulous and pertinent data collection process. Furthermore, the substantial sample size of 402 participants enhances the reliability of statistical analyses and facilitates more robust conclusions. The implementation of logistic regression analysis allows for a comprehensive exploration of the influence of various independent variables on SDM expectations, leading to deeper insights into the factors at play.

Study Limitations

This study's findings should be interpreted while considering its limitations. The sample's regional focus, drawn from the Dokuz Eylül University Education Family Health Centers, may limit the broader applicability of the results beyond this specific context. Identity confounding, stemming from the intricate influence of ego states on personality structure, presents challenges in controlling for all relevant variables, potentially impacting result accuracy. Furthermore, the cross-sectional design impedes the establishment of causal relationships and capture of dynamic changes over time. Longitudinal studies could offer a more comprehensive understanding of evolving SDM expectations. Although this study contributes valuable insights into SDM expectations and their relationship with ego states, its limitations call for further research. Future studies could address these limitations by employing more diverse samples and research methodologies, thus advancing our understanding of this complex phenomenon in primary care settings.

CONCLUSION

In conclusion, this study highlights that being a native of a specific region and having a chronic disease elevate the anticipation of shared decision making. Conversely, individuals with psychiatric illnesses exhibit lower expectations of shared decision making. Moreover, those residing with 3-5 individuals in the same household demonstrated higher SDM expectations compared with those living with fewer or more people. Notably, the ego states of patients accessing primary care services do not significantly impact SDM expectations.

Ethics

Ethics Committee Approval: The study was conducted using a cross-sectional analytical model. The study received ethical approval from the Dokuz Eylül University Non-invasive Ethics Committee (approval number: 2020/03-37, date: 03.02.2020).

Informed Consent: Informed consent was obtained from all participants.

Peer-Review: Externally peer-reviewed.

Authorship Contributions

Concept: G.G., V.M., Design: G.G., V.M., Data Collection or Processing: G.G., V.M., Analysis or Interpretation: G.G., V.M., Literature Search: G.G., V.M., Writing: G.G., V.M.

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