RESEARCH ARTICLE

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A Phenomenological Qualitative Study: Family Physicians Experiences of Consulting Older Adults

ABSTRACT

Objective: Due to the aging population, older adult health became important. Family physicians play an important role in the health of older adults. This study aims to identify the challenges family physicians experience in counselling older adults.

Method: A qualitative, phenomenological methodology was used. Authors conducted three semi-structured focus group interviews with 22 family physicians. The recorded interviews were transcribed, and thematic analysis was applied.

Results: The mean age of the participants was 33.68 ± 8.37. The mean professional years of the participating physicians were 8.77±8.26 years. Seven of the participants were women and fifteen were men. Three themes emerged: (1) patient-related factors, (2) physician-related factors, and (3) physician remedies.

Conclusion: There are positive and negative aspects to consulting older adults. Understanding the difficulties experienced can facilitate the solution. Physicians stated that there was no geriatrics training both in their medical school undergraduate and postgraduate curriculum. They also stated that they found themselves inadequate in this regard and that creates anxiety. Effective communication is important both physically and emotionally during the interview. In fact, communication and active listening skills can be taught and postgraduate training in geriatrics can be organized.

Keywords: Older Adult, Qualitative Research, Comprehensive Approach.

Fenomenolojik Niteliksel Bir Çalışma: Aile Hekimlerinin Yaşlı Yetişkinlerle Görüşme Deneyimleri

ÖZET

Amaç: Yaşlanan nüfusa bağlı olarak yaşlı yetişkin sağlığı önem kazanmıştır. Aile hekimleri yaşlı sağlığında önemli rol üstlenmektedir. Bu çalışma, aile hekimlerinin yaşlı yetişkinlerle görüşme konusunda yaşadıkları zorlukları tanımlamayı amaçlamaktadır.

Yöntem: Niteliksel, fenomenolojik bir metodoloji kullanılmıştır. Yazarlar 22 aile hekimi ile yarı yapılandırılmış üç odak grup görüşmesi yapmıştır. Kaydedilen görüşmeler yazıya dökülmüş ve tematik analiz uygulanmıştır

Bulgular: Katılımcıların yaş ortalaması 33,68±8,37 yıldır. Katılımcı hekimlerin meslek yılı ortalaması 8,77±8,26yıldır. Katılımcıların yedisi kadın, onbeşi erkektir. Üç tema ortaya çıkmıştır: (1) hastaya bağlı faktörler, (2) hekime bağlı faktörler ve (3) hekimin çareleri.

Sonuç: Yaşlı yetişkenlerle görüşmede olumlu ya da olumsuz yönler bulunmaktadır. Yaşanan zorlukları anlamak çözümü kolaylaştırabilir. Hekimler tıp fakültesi lisans ve mezuniyet sonrası müfredatı içinde yaşlı sağlığı eğitiminin bulunmadığını belirttiler. Bu konuda kendilerini yetersiz bulduklarını ve bu durumun kaygı yarattığını da dile getirdiler. Etkili iletişim, görüşme sırasında hem fiziksel hem de duygusal olarak önemlidir. Aslında iletişim ve aktif dinleme becerileri öğretilebilir ve yaşlı sağlığı konusunda mezuniyet sonrası eğitim düzenlenebilir.

Anahtar Kelimeler: Yaşlı Yetişkin, Niteliksel Araştırma, Kapsamlı Yaklaşım.

INTRODUCTION

As life expectancy increases, health care of elderly becomes more important. Aging has its own characteristics, like childhood, and examination is different from other patient groups due to the physiological changes that occur (1). Older adults are often assumed to be debilitated or dependent. This is not true for every elderly person. Each elderly person's health care needs are shaped in line with the characteristics of their own health and life dynamics. That makes evaluating elderly people difficult for physicians (2). As the elderly population increases, health problems encountered, and health needs are changing. Preventive and therapeutic health services should be provided so that they can live independently. The quality of life becomes a priority. Quality of life and factors affecting quality become as important as living for a long time. Recently, healthy aging strategies have been developed (3). On the other hand, incidence of many diseases increases with age. Accepting that health will deteriorate with age may cause the diagnosis of diseases to be delayed (4). Disease symptoms of older patients may differ from younger patients. Disease may progress insidiously in older patient or may present with atypical symptoms other than what clinicians used to expect older patients are a vulnerable group whose general condition can change rapidly, and patients are also more susceptible to drug side effects and drug interactions. The drugs to be selected, drug doses and treatment targets are different in older patients than in younger patients. In addition, treatments in this age group should be planned individually, considering the performance, expected life expectancy and living conditions (5).

Since physicians often faced with chronic diseases that require continuous follow-up, patient and physician cooperation become even more important. When cooperation is ensured, treatment success and adherence to treatment increase. Comprehensive assessment of the geriatric population is important for prevention and improvement of quality of life. A biopsychosocial approach based on family medicine is particularly important for older adult care. Preventive medicine includes many practices, and the aim is to increase and protect the quality of life not only of the person himself, but also of those around older adult. Public health policies should include providing comprehensive health care, appropriate health care, social services for older adults, and continuing education on this subject for health professionals (6). The World Health Organization has projects aimed at basic education for primary health care providers about the health needs of older adult patients (7). The United Nations Decade on Healthy Aging (2021-2030) aims to reduce inequalities in health and improve the lives of older people (2). A comprehensive public health response must address this broad range of experiences and needs. Within the framework of search for solutions to the increasing medical and social needs of the older people, family physicians have important tasks and undertake an important role as the first contact in older adult's health care. Primary health care requires a wide variety of skills, reflecting the complexity and heterogeneity of ageing population. These skills are also fundamental components of the family medicine residency curriculum. Although there are times in these trainings when they experience visits of older adults, there is not a specific training program about older adult care. However, there are still some challenges about consulting older adults (8). This study aims to describe challenges of family physicians' when consulting older adults.

MATERIALS AND METHODS

Study Design: This is phenomenological qualitative research in which family physicians' experiences were analysed (9). Thematic content analysis was carried out in accordance with qualitative research methodology and analysis approaches (10). Consolidated Criteria for Reporting Qualitative Research guidelines were followed (11). The research was approved by the Non-invasive Clinical Research Ethics Committee (date no: 12.07.2019-e.43255). Each participant gave written and verbal consent before the interview.

Participants & Sampling Procedures: We used purposive sampling method. Twenty-two physicians (6 family medicine specialists, 8 family medicine residents in final year of education, 8 family medicine residents in second year of education) were involved in the study. Participants were invited to scheduled meeting and each focus group met once. The mean age was 33.68±8.37. The mean year in the profession of the participating physicians was 8.77±8.26. Table 1 shows some characteristics of the participants. First focus group consisted of 8 family medicine residents in final year of education. The mean year in the profession of the participating physicians was 7.0±3.81years. Second focus group consisted of 6 family medicine specialists. The mean year in the profession of the participating physicians was 19.0±8.89 years. The third and last one consisted of 8 family medicine residents in second year of education. The mean year in the profession of the participating physicians was 2.87±0.83 years.

Data Collection Procedures & Instrument: Data was collected between January 2020- March 2020. The focus-group interviews were conducted in a quiet environment with appropriate physical conditions for the focus group meeting in a round table arrangement. The primary author, trained in qualitative research methods, facilitated all interviews. During the focus group interviews, primary author conducted the meeting while the second one observed the participants,

Table 1. Characteristics of the participants

Acronym	Gender	Age	Years in occupation as Family Physician	Focus group
A1	Female	28	3	1
A2	Female	30	5	1
A3	Male	31	5	1
A4	Male	41	15	1
A5	Female	32	7	1
A6	Male	35	9	1
A7	Male	34	8	1
A8	Male	28	4	1
B1	Male	45	19	2
B2	Male	43	20	2
B3	Female	56	31	2
B4	Male	51	26	2
B5	Male	32	8	2
B6	Male	35	10	2
C1	Female	28	3	3
C2	Male	29	4	3
C3	Female	27	2	3
C4	Male	27	3	3
C5	Male	27	2	3
C6	Male	26	2	3
C7	Female	28	3	3
C8	Male	28	4	3

took notes and oversaw the audio recording. Data collection in the study was achieved through face-to-face semi-structured interviews conducted with the participating physicians, during which the researcher asked the respondents open-ended interview questions that were devised following a literature review (Table 2). During the interviews, the questions were asked to the participant in a clear and understandable way, and specific subjects were investigated deeper through additional questions if necessary. After all, the open-ended questions had been asked; the respondents were left to discuss. If there was no departure from the topic, no intervention was made, and the respondents were free to speak.

Table 2. Semi-structured questions in focus group interviews

1.	How does the interview process with the older patient happen?
2.	What do you feel in the older patient interview?
3.	How do you manage older patient interview?
4.	What might affect your approach to the older patient interview?
5.	What effects the older patient interview?
6.	Why does the patient choose you?

The first focus group interview was held with eight family medicine residents with experience with older adults who were in their final year of education, and lasted 44 min. The second focus group interview lasted for 42 min and was conducted with six family medicine specialists who were working actively with older adults. The third focus group interview lasted for 50 min and was conducted with eight family medicine residents in their second year of education who had limited experience with older adults during their residency training.

Analysis: All focus group interviews were recorded and transcribed verbatim on the same day using Microsoft Word. Three authors who were trained in qualitative research methods took part in analysis. Two coders, with different backgrounds in their academic disciplines, independently read the transcripts multiple times to internalize the topics. Next, coders independently coded and cross coded transcripts. During the theme creation process, meaning units were re-examined and evaluated, and the notes taken by the second author during the interviews allowed the data to be conceptualized more accurately. Coders met weekly to discuss their analyses and interpretations and created a list of themes in which similar codes were condensed. After a total of eight analysis meetings, the third author reviewed them all, and all coders discussed and reached consensus on themes and subthemes (12).

RESULTS

The main themes grouped as: (1) patient related factors, (2) physician related factors and (3) the physician's remedies (Table 3).

Patient Related Factors

Common Health Issues: Older adults may have comorbidities and multiple drug use. It is more difficult to manage patients who use multiple drugs and have problems related to old age, which is an issue that has been mentioned many times and is expressed as follows:

"They open a bag full of drugs and pour them onto your table which makes you more stressful."(A7)

Another common issue in older patients is mental problems. Memory problems are common although it does not always extent of disease. Physicians who participated in the study mentioned it as a challenge.

"Since Alzheimer's and memory loss is common in older patients, these always affect communication."(B6)

"You ask a question, s/he answers another question in her/his mind."(A4)

"They can really jump from branch to branch while talking."(C8)

It is also a challenge for physicians, older patients accept a symptom as a part of daily life and think it is normal for their age.

"*They do not consider the diseases for which they receive treatment and medications as a disease*."*(A4)*

As stated by one physician, "*If they have a new problem, they see it as a disease*" *(A4),* adding that they no longer consider their chronic diseases as a disease, and so a comprehensive inquiry should be made rather than focusing only on the main complaint.

Tablo 3. Examples of Categories and Themes

DATA	Categories	Themes
"*Since the older adults has more polypharmacy and many accompanying comorbid diseases, patient management is more difficult and more complex, and the process takes longer than younger patients*." *(B6)* *"They are confused about their medicine a lot; what time they will take it, what they will do… the treatment process, like, just like children." (B3)*	Common health issues	Patient related factors
"When an older patient comes (to my clinic), I need to take his/her arm and carry him/her to examination table. If the patient falls, a trauma comes out of nowhere." (A3) *"Instead of listening to his companion, we should listen to patients…. what is the real problem for the patient. Companion may explain his/her complaint, but we need listen to 'real' patient, especially if he has any other problems deeper." (A7)*	Physical obstacles	
"T*ime, they want to spend with me is much longer than young patients…The patient leaves when we are done about health care but older patients sometimes want to talk afterwards about politics, they want to chat about their daughter-in-law.*" (B1)	Social challenges	
"We did not take geriatrics class. Our education was not suitable for this, young doctors know better. It didn't exist in our time; I feel such an inadequacy. Indeed, it is difficult to manage older patient." (B4) *"Our appearance is very effective. 'Are you a doctor, my child? Are you still studying med?' etc."* (A2) *"They may argue that 'I know more than you, I have lived more, these have happened to me more, I have always solved them like this', and they may oppose something you have just presented. Because they have a dogma, they believed in them and you can't change it all at once."* (C4) *"Of course, older patient is a cause for fear and anxiety. Because the reason for the old patient's visit may be only one thing, but we know that many things can come out of it, investigating more, questioning more and fear of skipping something is a greater concern."* (A1) *"You wonder what will happen... they request from you to heal, but what you can do is limited, and it comes back to you as a psychological burden, you get sad..."* (B4)	Skills of physician	*Physician related factors*
"In general, there are two possibilities, they come for the purpose of prescribed drugs, or they have many very chronic diseases…the treatment of these diseases." (A6) *"We already have prejudices about it. I wonder if s/he will have too many complaints, does he have comorbidities, there are drug side effects, the frail elderly… And we need to think about them. We start with question marks when the old man/lady enters the room." (A2)* *"My anamnesis will take longer, I don't know if he will be able to tell me about his problem, or sometimes you see audio devices or something… Inevitably, as soon as the patient enters, they already appear." (A3)* *"You know, since most of them have such a chronic pain, as soon as the patient enters, I have a bias that there is no big problem." (A8)*	Prejudice due to common problems	
"*Maybe speaking a little louder and slower; using words that s/he can understand; or maybe using basic language*." (C5) *"Contact is critical indeed. Patting them on the back and holding their hand, or something similar, really boosts their confidence."* (B1) "*It may be an advantage to have someone who knows the situation and who can explain the situation better, as it allows us to communicate better with the patient during the examination.*"(C5) "*Knowing the patient also increases the number of applications of patients. S/He [the patient] says, 'My doctor knows me, s/he knows about my complaint as s/he has been following me for years', and so s/he feels s/he can trust the family physician more*." (A1).		The physician's remedies

"Their own body perceptions can be different."(B1)

"They have accepted the pain; their pain thresholds are very different."(A7)

Physical Obstacles: The vigour of the patient greatly affects the physician's physical examination. Physical insufficiency leads to anxiety about not being able to undergo the examination comfortably and can lead to time management problems for physicians:

"*The physical condition of the patient is critical. Will I be able to examine the patient the way I want? This affects my consultations a lot.*"*(A2)*

"When an older patient with walking difficulties comes... I just feel uncomfortable in terms of time management."(C8)

However; communication is another obstacle when assessing an older adult. Age-related disabilities are difficult to solve. In consultations, it is important that the patient and the physician understand each other as much as the physician's impressions of the patient. It is worth emphasizing the effects of both the patient's cognitive problems and hearing difficulties, which can cause communication barriers:

"*Communication problems makes me think. For example, will s/he be able to hear me and understand me sufficiently, or will s/he give an inappropriate reply to the question I ask?*"*(A5)*

"Sometimes they can express their complaints with very different words, the language they use can be outdated"(B1)

"His companion speaks. Patient really can't tell (about his/her own problem) properly. We understand patient's complaint after all, we don't have any other choice, frankly."(A8)

Social Challenges: It is not always easy to find companion for older adults "*One of the biggest problems in older adults is loneliness*" *(A6)* and it was emphasized that health care is not just about medical assistance, there is also a need of holistic approach that considers social aspects.

"… s/he is socially lonely, unable to buy his medication, maybe the medication I prescribed will be an additional burden for him…that is a big problem for her/him"(A5)

Another issue mentioned during the interviews was the mood of the patients. Physicians stated that changing patient emotions also affected their own practices, making interviewing difficult.

"Old people, maybe a little more, how can I say, touchy?"*(A3)*

"Not all older people are sweet, I mean, there are very sweet older people, but there are some who are so weirdly grumpy and targeted to quarrel."(B3)

"… they have lived 70-80 years, all those problems piled up, they carry on their back. You know, they don't travel around the world like these retirees in the west (countries), our people seem to be more worn out both physically and spiritually."(B4)

Physician Related Factors

Skills of Physician: Skills of the physician is another challenge mentioned in focus groups. physicians are trying to cope with many different problems at the same time in every older patient who enters the door. They know that they must think about many issues related to the patient, but they are not sure whether they can deal with them.

"We feel inadequate with polypharmacy and many chronic diseases in older patients."(B6)

"Also, it is very difficult to find the real reason, the real reason of urgency."(A8)

In addition, age or social differences between physician and patient can also cause a doubt in the patient about the competence of the physician. The physician who is aware of these doubts is affected.

"There are also those who enter (the room) to argue with the doctor. And some who come with prejudice so that doctors should understand what they mean by looking at their face..."(A2)

As a result of all these different reasons, our physicians stated that they experienced fear and anxiety or feelings of inadequacy while meeting with the patient. They explained that these feelings limited their abilities when examining them.

"When you see an elderly patient, you have the lottery surprise box, a surprise egg."(C4)

"S/He tells a lot of things. I have concerns about whether I will be able to analyze the important ones correctly."(A5)

"Since they have a lot of extra troubles, there is a concern whether I will be able to afford all these, on the one hand, there is the fear that I may miss something."(A2)

Physicians also mentioned confusing emotions that affect them when they meet an older patient. They stated that they had to cope with these feelings during their interviews and that they had to suppress them in order to act professionally.

"...I usually feel sad if s/he lives alone."(A6)

Prejudice due to Common Problems: Our physicians mentioned that they started to visualize some scenarios that are common in older patients as the patient enters the room. This can be explained by the phase in which the physician develops a theory about the patient, which exists in interview techniques, but the fact that it reaches the dimension of being biased may also affect the physician's right decision about the patient. It may affect the patient-centered approach.

"In general, there are two possibilities, they come for the purpose of prescribed drugs, or they have many very chronic diseases…the treatment of these diseases."(A6)

"He comes and says, 'My knee hurts, my child,' he wants medicine, he wants painkillers. That is why we may ignore the bigger problems in the very old patient."(A8)

The Physician's Remedies: Physicians consider actions such as raising their voice and speaking in turn during consultations with older adults as potential solutions to hearing problems, although it was also stated that examining patients at home could alleviate some of the physical barriers:

"*Maybe speaking a little louder and slower; using words that s/he can understand; or maybe using basic language*."(C5)

Most physicians noted that they feel they are closer to their older adults and said that being friendly makes conversation better, involving contact with the patient, the use of body language and using a sincere approach:

"*Sometimes holding their hand or patting their back, makes the patient happier. After conducting an examination, having contact with the patient while explaining the situation can motivate them*."(C4)

"… (when they come to my office) I treat them like one of my relative entering my office."(C8)

Improving the physical condition of family health care centre can also facilitate consultation. Participants stated that making the examination room and throughout the family health center suitable for elderly patients may ease of movement and increase comfort. There are mandatory regulations in our country to ensure this physical comfort. Participants stated that improving the physical conditions of the family health center could help the elderly overcome their physical disabilities, *"legal regulations such as 110 cm wide doors and ramps for the disabled"* (B6).

Communication is easier if older adult attends the consultation with a companion:

"*It may be an advantage to have someone who knows the situation and who can explain the situation better, as it allows us to communicate better with the patient during the examination.*"(C5)

The holistic approach and continuity of care associated with family medicine are the two principles that help family physicians most in overcoming the challenges they encounter.

It was stated that it was important among older adults to feel that their doctor is listening to them. As stated by one participant, *"… very important they feel like we are listening to them, as they may not feel this with another physician.*"(B1)

The appreciation of older adult patients when compared to that of other patient groups and the patient's ability to express himself/herself, create positive feelings in physicians. It was further stated that older adult patients tend to behave with more respect, and so the consultation process tended to be easier.

"*We might not be able to solve the problem completely, but if I can make him/her more comfortable, and they leave here satisfied, it is generally pleasing for me*."(A5)

DISCUSSION

Family physicians play an important role in the health care of the older adults (6). Physicians should support patients not only in case of illness but also in healthy aging. Primary care physicians require a wide range of skills to meet the needs of the aging population. Even though they contact with the elderly in training, there may be deficiencies in specific training regarding elderly care. However, there are still some challenges in counseling older adults (8). This study aims to identify the challenges family physicians experience when consulting older adults.

After analysis of this research data, three themes emerged: patient-related factors, physician-related factors, and physician remedies. From the physician's perspective, the problems in the elderly patient's ability to express their-selves during patient-physician consultation and examination are not clearly known. It is important to make this clear. It is inevitable that physicians need certain skills in consulting elderly patients in terms of diagnosing, preventing and maintaining health, and having good patient-physician relationship. It is also important that this is revealed by physicians; because it is a skill that can be improved. Obtaining this information will be a guide for this improvement. While physicians can find solutions to some of the problems in management of elderly patients, they cannot find solutions to others. Revealing not solved one's ease to think about solutions and find a way out.

As people age, they are more likely to experience several conditions (2). Changes due to nature of aging and common health issues of older patients can be challenging. Like literature, in our study, common health issues, comorbidities and polypharmacy were some reasons that made it difficult to interview the older patient (13). Studies have shown that multi-morbidity and polypharmacy increase with age, while the use of different medications causes problems in patients, which justifies the claims of the respondent physicians (14,15).

The challenges include communication barriers which is the basis of the patient-physician interview. Problems such as hearing problems, mental status changes, vigor of the patient also effect communication (2). Physicians mentioned that the presence of companion both facilitates and complicates consultation. It facilitates history taking and allows more information; helps physical movement, such as undressing during the examination; shortens the examination duration. Unfortunately, it may affect the depth of interview and avoiding private topics, but physicians stated brief talk is better due to workload.

Loneliness of the elderly has also been identified as an obstacle by physicians. Having someone at home to observe whether they are using the given treatment or suggested change correctly

makes it easier to assess compliance with the changes. There is also a strong relationship between loneliness, mood, and depression in older adults (16). A wide variety of interventions have been developed to combat loneliness and social isolation in the elderly (17). Not every person experience loneliness in the same way or to the same degree, and it is stated by our participants that ignoring the symptoms that exist as a part of old age is a challenge. Here, physicians should be alert to some issues that the patient himself may consider unimportant. In society, being old mostly contains negative statements. In fact, the definition of old age is stated as "showing the effects and features of increased age" (18). Thus, aging is considered as a process that should be avoided and undesirable. The society's view of aging, perception and prejudices may affect the services provided to older people. Health professionals need to address these ageist society attitudes, which can lead to discrimination, affect older people experience healthy aging (2). Not only the attitude of the physician to older patient, but also vice versa may be biased. The large age gap may cause the patient to treat the doctor as he treats his/her child. "I am wiser when I am older" also compels the physician. This cultural feature is very difficult to overcome. As mentioned before, while patients accept and ignore some symptoms as a part of aging, the physician may experience the same delusion. The prejudices of old age come into play and the evaluation of patient is affected on which physician may have overlooked another underlying problem. Participants are aware of these biases and that causes anxiety. However, they did not propose any solution to change.

Due to the nature of medicine, it is necessary to be solution oriented. In the focus group interviews, it was spontaneous to start talking about solutions. Physicians make some changes to enable patients more comfortably. Some practices to make older patient-friendly health center are also on their agenda. To make communication clear, speaking loudly and slowly was accepted as a solution to problems related to hearing. Slower speaking rate at a higher pitch and louder, repeating instructions and using basic words, and less grammatical complexity may help in communicating with the older adult patient (1). It is stated that if a good level of communication with the patient is not established, the patient will not trust the physician and as a result, the physician will be deprived of the patient's medical history (19). With sense of trust between the patient and the physician, a social safety net around these people can be contributed (20). A comprehensive approach when consulting older adults can have several benefits (6). Good communication can also support preventive health, diagnosis, treatment and decision-making. In this study, participants stated that they care about patients' emotions, and there is a scoping review in the literature that emphasize the importance of paying attention to patients' emotions when questioning their physical health and taking their stories (19). All participants approached their patients with similar goals but used different methods. Considering these data, the participants believed that consultation challenges are mostly attributable to patient-related or physician-related factors. In another study, difficulties encountered in the management of older adult patients were classified as those attributable to the patient, physician, and health system which was never mentioned in our research (21). Physicians mentioned that there is no geriatric training in their training that causes anxiety. However, training about communication and active listening skills was not mentioned as a solution which teachable and post-graduation education can be arranged about geriatrics.

The results of the research were discussed in detail. Revealing these findings may be a guide for family physicians to improve their skills in consulting elderly patients and take them to the next level because the patient-physician consultation is a learnable and fixable skill. Finding these and getting remedies from physicians, understanding what they experience and what deficiencies they feel about elderly patient consultation can help it. This study which explores family physicians' experiences of consulting older adults in primary care may provide valuable information for improving primary care. Family physicians who work in an aging society need to know more about characteristics of elderly patient population. Family physicians need to know their role in elderly care and basic competency requirements to develop evaluation strategies.

LIMITATIONS

This study has some limitations. First, the nature of qualitative study does not allow determining causality. Additionally, this study cannot represent larger population due to the non-probabilistic sampling method. Second, results may have been influenced by participants personal expressions, but since qualitative research is conducted with a sample appropriate to the research question, it aims to understand what participants experience on the issue. Further research may be planned to measure perceptions expressed by participants in our study.

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