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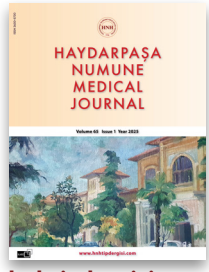

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ORIGINAL ARTICLE

Attitudes and Behaviors of Emergency Room Physicians Regarding Prescribing Oral Anticoagulants for Newly Diagnosed Atrial Fibrillation Patients at Discharge

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Abstract

Introduction: Current guidelines on atrial fibrillation (AF) recommend prescribing oral anticoagulants (OACs) for high-risk patients. However, the rate of OAC prescriptions by emergency department (ED) physicians remains lower than expected. This study explores the barriers that prevent ED physicians from prescribing OACs at discharge for newly diagnosed AF patients.

Methods: This qualitative case study included semi-structured interviews with 26 emergency medicine specialists and residents at a tertiary care hospital with 280,000 annual emergency visits. The interviews comprised 26 open-ended questions across three sections. Thematic analysis was used to identify factors influencing physician decision-making.

Results: Inductive content analysis of the interviews revealed three key themes: (1) management of AF in the ED, (2) thromboprophylactic approach, and (3) opinions and recommendations. Physicians frequently consulted cardiologists for AF management. The primary barrier to prescribing OACs was concern over inadequate follow-up after discharge. Physicians emphasized the need for healthcare system revisions, particularly early cardiology outpatient follow-ups post-ED discharge and long-term monitoring by family physicians, to increase OAC prescription rates.

Discussion and Conclusion: The study highlights the need to clearly define the role of ED physicians in managing AF patients. A comprehensive improvement plan should address systemic barriers, establish a seamless diagnosis–treatment–prescription–follow-up chain, and enhance physician education. These measures could improve adherence to guidelines and optimize care for AF patients.

Keywords: Anticoagulant drug; atrial fibrillation; drug prescribing; emergency medicine.

Atrial fibrillation (AF) is the most frequently diagnosed cardiac arrhythmia within emergency medical facilities[1]. The prevalence of AF in the United States has been projected to experience a significant increase in the coming years. In 2010, it was estimated to affect 1.2 million individuals; however, it is estimated that this number will rise to 2.6 million by the year 2030, representing a more than twofold increase[2]. It has been widely acknowledged

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that emergency physicians often fall short of initiating oral anticoagulant (OAC) therapy in patients with AF who are at risk of stroke in accordance with established guidelines[3]. Approximately 25% of individuals newly diagnosed with AF receive their diagnosis in an emergency department (ED) setting. This highlights the significance of ED as a crucial site for the identification of AF and initiation of appropriate treatment[4]. Despite the prevalence of AF diagnoses in ED, a significant proportion of patients who are identified as being at a high risk of stroke are not prescribed OAC therapy. The prevalence of OAC prescriptions in this patient population is estimated to range from 20% to 60%. This disparity underscores the need for improvement in the identification and management of patients with AF in ED settings[5-7].

The guidelines for the management of AF in ED have not undergone sufficient validation, as compared to the guidelines recommended for the management of inpatient populations with AF. This disparity highlights the need for increased attention and resources dedicated to the validation of AF management guidelines in ED, in order to ensure that patients receive appropriate and effective care[8-10]. The variability in physician attitudes and practices for the management of AF in ED has been attributed to the insufficient validation of guidelines for AF management in this setting. This variability has led to a multitude of potentially preventable hospital admissions and underscores the need for standardization and improvement in AF management protocols in ED[11].

In view of the potential impact on the prevention of AF-related strokes and other thromboembolic events, it is deemed of utmost importance to determine the barriers to the prescribing of OAC drugs in accordance with the guidelines for newly diagnosed AF patients in ED.

In this study, we aimed to assess the extent to which emergency medicine residents and specialists utilize guidelines in the management of AF and their attitudes towards assessing the risk of stroke and implementing preventive measures. Furthermore, we aimed to examine the factors affecting physician decision-making and the use of OAC drugs, as well as reservations about prescribing OAC drugs and thoughts on optimal AF management.

Given the limitations of quantitative methods in apprehending the underlying concerns, biases, and other intangible parameters that may impact physician behavior, we chose to employ a qualitative approach in evaluating the attitudes and behaviors of emergency physicians in the management of AF.

Materials and Methods

This study was conducted in accordance with established Good Clinical Practices guidelines and the principles outlined in the Declaration of Helsinki. The study received ethical approval from the Istanbul Medeniyet University Göztepe Training and Research Hospital Clinical Research (approval number 2021/0364, dated 30.06.2021).

The research employed a qualitative case study design. This approach emphasizes the exploration and understanding of contemporary dynamics within a defined scenario[12].

The study was conducted using semi-structured interviews with emergency physicians working in an urban tertiary academic hospital with a yearly emergency room volume of 250,000 patients. We included all emergency physicians in our facility. The participants were asked open-ended questions related to the study topic face to face. The interview questionnaire, which was divided into two sections, is presented in Appendix 1. These sections aimed to maintain a structured and organized flow of the interviews and to facilitate the thematic analysis of the data: 1) attitudes towards the management of AF patients in the ED, 2) thromboprophylaxis approach at the time of discharge for AF patients.

This qualitative study aimed to examine the attitudes and practices of emergency medicine specialists and assistants regarding the initiation of OAC at the time of discharge for newly diagnosed AF patients in the ED. The study population consisted of 26 emergency medicine practitioners, consisting of 6 specialists and 20 assistants, who had participated in the management of at least one newly diagnosed AF patient in the past month.

Data was collected through semi-structured interviews, using an interview form developed for the purpose of the study, which included open-ended questions related to the management of AF patients in the ED, the thromboprophylactic approach at discharge, and opinions and recommendations on diagnosis, treatment, and follow-up. The interviewer was trained in interview techniques by a sociologist expert in the field prior to conducting the study.

The participants were asked to read and sign an informed consent form prior to the interview. The interviews took an average of 20 minutes and were conducted between October 10, 2021, and January 10, 2022, with a total data collection period of three months. The study population consisted of 9 female and 17 male participants, with ages ranging from 25 to 41 years and experience ranging from 1 to 15 years.

Table 1. Attitudes towards Management of AF Patients in the Emergency Department

Pathway A1	Pathway B1	Pathway C1	Pathway D1	Pathway E1	Pathway F1
Assessment of AF patient (f:103)	Sources Used for AF Treatment Decision (f:39)	Factors Affecting the Decision to Admit or Discharge AF Patients (f:69)	Patient-related Factors Affecting the Decision to Initiate OAC in Discharge (f:37)	Non-patient Related Factors Affecting the Decision to Initiate OAC in Discharge (f:30)	AF Patient Follow-up and Referral Plan After Discharge (f:31)
1. Cardiology consultation (f:26)	1. CHA2DS2-VASc score (f:24)	1. Decision to observe (f:55)	1. CHA2DS2-VASc score (f:14)	1. Problem with inability to enter follow-up in outpatient clinic (f:12)	1. Planning (f:17)
2. Use of thrombotic agents (f:26)	2. Not used (f7)	a. Additional complaints (f:11)	2. Patient's social support status (f:9)	2. Problem of insurance reimbursement for NOAC medications (f:9)	a. Referral to cardiology (f:11)
a. Starting LMWH (f:21)	3. AHA guideline (f3)	b. Rate control (f:11)	3. Presence of additional diseases (f:4)	3. No external factors according to guidelines (f:6)	b. Call to emergency service (f:6)
b. Starting Warfarin (f:3)	4. HAS-BLED score (f2)	c. Vital signs (f:9)	4. Patient's age (f:3)	4. Doctor's lack of knowledge and experience (f:2)	2. No planning (f:14)
c. Starting ASA (f:2)	5. Clinical experience (f1)	d. Unstable hemodynamics (f:8)	5. Presence of additional medications (f:2)	5. Hospital overcrowding (f:1)	a. Control in cardiology outpatient clinic (f:14)
3. Hemodynamic assessment (f:14)	6. ESC guideline (f1)	e. AF is a new diagnosis (f:7)	6. Patient's mental capacity (f:1)		
4. AF rate control (f:13)	7. Other current recommendations from internet sites (f1)	f. Need for monitoring with defibrillator (f:3)	7. Educational level (f:1)		
5. Existence and nature of additional diseases (f:8)		g. Evaluation with specialist physician (f:3)	8. Distance from health services (f:1)		
6. Observation (f:7)		h. Presence of chest pain (f:2)	9. Level of bleeding risk (HAS-BLED) (f:1)		
7. Evaluation with ECHO (f:3)		i. CHA2DS2-VASc score (f:1)	10. Patient's gender (f:1)		
8. Determination of CHA2DS2-VASc score (f:3)		2. Discharge decision (f:14)			
9. Need for etiological assessment (f:1)		a. Absence of need for observation (f:7)			
AF rhythm control (f:1)		b. Cardiology specialist's discharge opinion (f:6)			
		c. Emergency specialist's discharge opinion (f:1)			

AF: Atrial Fibrillation; OACs: Oral Anticoagulants; LMWH: Low-Molecular-Weight Heparin; NOACs: New-Generation Oral Anticoagulants; ASA: American Society of Anesthesiologist; ECHO: Echocardiography; HAS-BLED: Hypertension, Abnormal liver/renal function, Stroke, Bleeding history or predisposition, Labile INR, Elderly (age >65 years), Drugs/alcohol concomitantly, CHA2DS2-VASc: Congestive heart failure, Hypertension, Age ≥75 years (2 points), Diabetes mellitus, Stroke/transient ischemic attack/thromboembolism (2 points), Vascular disease, Age 65–74 years, Sex category (female),

Statistical Analysis

Content analysis technique was used in the analysis of the data in this study, which aimed to evaluate the opinions of emergency medicine specialists and assistants regarding the initiation of OAC at the discharge of newly diagnosed AF patients through qualitative semi-structured interviews. The participants consisted of 6 emergency medicine specialists and 20 emergency medicine assistants working in a tertiary academic hospital with an annual emergency room volume of 250,000 patients in Istanbul, Türkiye.

These narratives were independently reviewed and collated using a qualitative thematic framework[10] by members of the research team using NVivo 9.1 software (QSR International Pty Ltd, Doncaster, Vic, Australia), resulting in 1074 views. Interview transcripts were independently reviewed by multiple researchers. The coding resulted in the identification of 1,074 individual views across different themes. An independent physician categorized the responses separately. Emerging findings were discussed, and themes were negotiated and agreed upon. We used an inductive coding approach, allowing themes to emerge organically from the data. A high level of coding consistency, calculated to be 93.2% (1001/1074), was achieved after re-evaluating the remaining 73 codes that could not be agreed upon.

Results

The study population consisted of 26 emergency medicine practitioners, including 6 specialists and 20 assistants. After conducting the content analysis, the data collected from the participant responses were categorized and grouped under three main themes. These themes were:

1. attitudes towards the management of patients with AF in the ED,
2. thromboprophylactic approach at discharge of AF patients,
3. opinions and recommendations.

Table 1 provides insight into the attitudes held by medical professionals towards the management of AF patients in the emergency setting. Emergency physicians assess AF patients using various clinical tools and guidelines. A total of 103 answers detailed their approach to AF management, highlighting variability in decision-making based on clinical assessments and consultation. The CHA_2DS_2-VASc score was mentioned by 24 participants, while other sources such as the AHA guideline,[3] HAS-BLED score (2), ESC guideline (1), and clinical experience (1) were also referenced. Decisions regarding patient observation were influenced by factors such as additional complaints (11), rate control needs (11), vital signs (9), unstable hemodynamics (8), and the need for cardiac monitoring (3). The choice to discharge AF patients was driven by absence of need for observation (7) and the cardiology specialist's opinion (6).

Table 2 highlights the thromboprophylactic approach adopted at the time of discharge of AF patients. Among 53 different answers, the decision to start OAC at discharge was discussed, with some preferring new-generation oral anticoagulants (NOACs) (56). The most cited considerations in drug selection included low risk of complications (23), ease of administration (11), high safety profile (7), ease of monitoring (7), and cost (6). Referral to a cardiology specialist was a preferred strategy among 11 participants, while 14 participants planned for cardiology outpatient follow-ups instead.

Table 3 presents sample ideas collected from participants and categorizes them based on the themes that emerged from the data. Examples from the pathways in Table 1 and Table 2 have been provided, with the notation K_(number) representing the participant and their corresponding identification number (Table 3).

Discussion

In our study, we analyzed the approaches and attitudes of emergency physicians to newly diagnosed atrial fibrillation patients, especially the factors affecting their treatment approaches. When comparing our findings to those of previous studies, it is essential to consider the potential differences in clinical practice across regions and healthcare systems. For example, the study by Kea et al.[13] in the USA examined OAC prescription practices among emergency physicians; however, their findings may not fully reflect the practices observed in Türkiye or other regions.

While directly assessing the practice of prescribing OAC according to guidelines in the study by Kea et al.,[13] in our study, we observed that the recommendations made by the cardiologists regarding the prescription of OAC in patients diagnosed with AF were strictly adhered to by the emergency physicians. This finding contrasts with the results of a previous retrospective study conducted in the USA, which revealed that only 5 out of 40 AF patients who were not recommended OAC by the cardiologist received OAC prescriptions from the emergency physician, whereas 7 out of 10 AF patients who were not prescribed OAC by the emergency physician were seen for consultation with a cardiologist. This discrepancy highlights the need to

Table 2. Thrombophylactic Approach in Discharge of AF Patients

Pathway A2	Pathway B2	Pathway C2	Pathway D2	Pathway E2	Pathway F2
Decision to Initiate Oral Anticoagulation in Patients to be Discharged (f:53)	Choice of New Generation Oral Anticoagulant (NOAC) (f:56)	Factors Preventing the Prescription of OAC (f:44)	Factors Affecting Drug Choice (f:100)	Decision to Initiate OAC in Patients with Previous AF but not on Anticoagulation (f:41)	Effect of Antithrombotic Drug Use for Another Condition on Prescribing Anticoagulants (f:34)
1. No (f:46) a. LMWH and thromboprophylaxis decision (f:18) b. Consultation with cardiology specialist (f:13) c. Problem of not being able to follow up with patient (f.5) d.a (f:4) e. Lack of trust in patient (f:3) f. Avoiding responsibility for side effects (f:2) g. Not having enough time to provide patient with detailed information (f:1) 2. Yes (f:7) a. If followed by outpatient clinic, I may prescribe(f:7)	1. I do not prefer (f:56) a. Lack of information (f:18) b. Lack of experience (f:17) c. Uninsured medication (f:9) d. Belief in cardiology specialist responsibility (f:6) e. Belief in uncertain side effects (f:5) f. Belief in insufficient research (f:1)	1. Difficulty in obtaining outpatient appointment/ concern of lack of follow-up (f:12) 2. Patient's socio-cultural level (f:8) 3. No obstructing factor (f:5) 4. Lack of knowledge and experience (f:5) 5. High demand at emergency department (f:4) 6. Distance of patient from healthcare facility (f:4) 7. Problem with insurance reimbursement (f:2) 8. Different doctor approach with each visit (f:1) 9. Patient noncompliance with medication (f:1) 10. Variation in medication doses from patient to patient (f:1) 11. Severity of complications with OACs (f:1)	1. Low risk of complications, low side effects (f:23) 2. Low frequency of daily administration (f:11) 3. Easy to swallow, easy to administer (f:11) 4. Route of administration (f:10) 5. High safety, high therapeutic index (f:7) 6. Ease of monitoring drug levels (f:7) 7. Cost (f:6) 8. Size, taste, and presence of gastrointestinal irritation (f:5) 9. Low drug interactions (f:5) 10.Effectiveness, potency (f:4) 11.Established/experienced drug (f:4) 12.Easily accessible (f:2) 13.Newly released drug (f:1) 14.No need for additional drug use (f:1) 15.Pregnancy status (f:1) 16.Lack of cumulative toxicity (f:1) 17.Availability of insurance reimbursement (f:1)	1. don't prescribe the medication myself (f:17) a. Consultation and referral to cardiologist (f:16) 2. I will start if there is an indication (f:5) a. LMWH (f:3) b. OAC (f:2) c. Consultation with emergency specialist (f:3)	1. Doesn't affect (f:22) a. I'm not starting oral anticoagulant anyway (f:12) b. Consultation with relevant department (f:8) c. I will start anticoagulant (f:2) 2. Effects (f:12) a. Consultation with cardiologist (f:6) b. Referral to relevant department (f:4) c. Consultation with emergency specialist (f:1) d. Prescribing medication (f:1)

OACs: Oral Anticoagulants; LMWH: Low-Molecular-Weight Heparin.

Table 3. A table showing sample themes and ideas for assessment and thrombophylactic Approach of AF patients by emergency physicians

Themes	Sample ideas
A1	"If the diagnosis is new onset AF, I consult with a cardiologist and assess whether there is an indication to start anticoagulants. For this, we use CHA2DS2-VASc. I prefer to observe and monitor new AF cases with cardiac monitoring. When it comes to AF, warfarin comes to mind first. Apart from that, I don't think there is an indication for the use of new-generation oral anticoagulants in the emergency department. I am in favor of oral anticoagulant therapy being prescribed and monitored by a cardiologist, not emergency physicians. In new AF cases, there may also be an underlying cardiac cause for the development of AF. Further investigation may be necessary." (K_25)
B1	"I approach patients according to the guidelines of the AHA and ESC. I don't use the CHA2DS2-VASc scale very often. I start by considering the patient's additional illnesses. I don't need to calculate it because even if the patient scores 0-1 points on the CHA2DS2-VASc, I start LMWH anyway. When patients go to cardiology outpatient clinics and there is no indication for anticoagulation, I think that the LMWH treatment I started will be discontinued." (K_10)
C1	"I observe with the purpose of consulting a more experienced assistant/consultant." (K_20)
D1	"I start LMWH treatment for all patients. There is no difference in the situation from patient to patient. I adjust the dose according to the kidney function tests. Nowadays, since the use of new-generation anticoagulants has become widespread, I generally don't start warfarin. I am concerned about the very high levels of INR. Patients may not be able to follow up. When NOACs are prescribed by emergency physicians, insurance reimbursement cannot be made to patients. Therefore, only warfarin remains. There is no possibility to adjust its dose from the emergency department. That's why I don't start warfarin. I prescribe six doses of LMWH and recommend that the patient go to the cardiology outpatient clinic within 2-3 days. They will start OAC drugs there." (K_07)
E1	""I don't think my level of knowledge and experience regarding oral anticoagulant drugs is sufficient, so I hesitate to start them." (K_26)
F1	""If I discharged a newly diagnosed AF patient by starting OAC without consulting a cardiologist, I make sure to use my personal connections to help the patient find an appointment to the outpatient clinic for follow-up. If they are unable to find an appointment, I recommend that they go to the emergency department for INR monitoring." (K_25)
A2	"I do not discharge patients with oral anticoagulants. I prescribe them only if recommended by a cardiologist. I don't know which dosage to start or how to monitor them, and my reluctance to take on the responsibility for potential complications is also a factor. Even if I knew the patients would be monitored, my decision wouldn't change." (K_03)
B2	"If the insurance covered prescribing NOACs, I might consider writing prescriptions. But since I haven't written any yet, I haven't felt the need to do any research. That's why I have a lack of knowledge and experience about the medication." (K_06)
C2	"I have no problem during the management of the emergency department. However, I don't think it's our responsibility to manage AF patients after discharge. Our responsibility is to stabilize the patient with AF, and that's it." (K_13)
D2	"The drug has been on the market for a long time, it is not new, has a low side-effect profile, the price of the drug, its cost, low allergen drugs, pregnancy category" (K_12) "It is easy to absorb, it reaches the effective dose quickly, the way the preparation is used (im-oral-subcutaneous)." (K_18) "No need for drug level follow-up, no side effects and complications, low cost" (K_23) " I would like it to be effective, potent, have a low risk of complications, have few side effects, and have a wide therapeutic index range" (K_03)
E2	"If the CHA2DS2-VASc score is high, I would still consult a cardiology specialist. I would manage patients with a new diagnosis of AF in the same way. I would start LMWH treatment and follow the recommendations of the cardiology specialist." (K_11)

CHA_2DS_2-VASc: Congestive heart failure, Hypertension, Age ≥75 years (2 points), Diabetes mellitus, Stroke/transient ischemic attack/thromboembolism (2 points), Vascular disease, Age 65–74 years, Sex category (female); AF: Atrial Fibrillation; AHA: American Heart Association; ESC: European Society of Cardiology; LMWH: Low-molecular-weight heparin; INR: International normalized ratio; NOAC: New-generation oral anticoagulant; OAC: Oral anticoagulant.

consider the role of various factors, such as the healthcare system, population demographics, and physician beliefs, in influencing the approaches taken by emergency physicians in prescribing OAC for AF patients.[14]

The majority of the emergency physicians considered their role in the management of AF patients to be limited to diagnosing and referring the patient to a cardiologist, with only a minority starting oral anticoagulant therapy. This approach may reflect the perceived risk of bleeding associated with oral anticoagulant use, which emergency physicians may feel less comfortable assuming, compared to the responsibility for bleeding associated with a drug prescribed by the cardiologist.

However, the participants did acknowledge that certain factors, such as the availability of early cardiology appointments and a lack of knowledge and experience, may contribute to an increased frequency of oral anticoagulant prescribing by emergency physicians. When making decisions about prescribing OAC at discharge for AF patients, emergency physicians considered patient-related factors such as the presence of comorbidities, age, and gender. These factors are aligned with components of the CHA_2DS_2-VASc score, commonly used to evaluate the risk of stroke in patients with AF.[15]

In our study, the reasons behind the choice not to prescribe OAC in patients with newly diagnosed AF at discharge from the ED were also explored. The findings indicated that several factors associated with the patients, such as their lack of social support and low education level, played a significant role in the decision of not prescribing OAC. The emergency physicians reported a concern that these patients may not use the anticoagulant medication appropriately, leading to inadequate stroke prophylaxis. This is in line with a previous study, which showed that patients in lower-income quintiles have an increased risk of hospitalization for warfarin-related bleeding compared to those in higher-income quintiles. These findings highlight the importance of considering patient-related factors in the decision-making process for prescribing OAC in AF patients.[16]

A study conducted in Canada analyzed the socioeconomic status of AF patients who switched from warfarin to dabigatran between 2008 and 2010, a time when dabigatran was not yet covered by insurance reimbursement. The results indicated that 11.4% of patients in the highest income quintile switched to dabigatran, compared to 7.3% in the lowest income quintile, and a significant difference was observed at the 50% level.[17]

The utilization of NOACs for stroke prophylaxis in AF patients has been on the rise since 2010. In a recent study conducted in Türkiye, it was found that emergency physicians did not prescribe NOAC.[13] It is observed that the participants had not yet incorporated the use of NOAC in their clinical practice. These findings suggest the need for further studies to evaluate the extent of factors that impact the management of AF in the ED and the need for physician education and awareness on NOAC.[18] This may be attributed to a lack of knowledge and experience with these drugs among the emergency physicians participating in the study. Some participants acknowledged their limited understanding of NOACs. However, a deeper examination of the issue suggests that the jurisdiction of emergency physicians regarding NOACs requires further evaluation.

In Türkiye, the cost of NOACs is not covered by insurance if prescribed by emergency physicians but can be reimbursed if prescribed by specialists including cardiologists, pulmonologists, cardiovascular surgeons, or neurologists, based on a six-month medical board report with the participation of at least three of these specialists. There is a need for further research to compare the cost of complications that may arise in high-risk AF patients diagnosed in the ED and discharged without prescribing NOAC due to insurance reimbursement issues, with the cost of prescribing NOACs by emergency physicians.

In our study, the majority of participants reported that they prescribe low-molecular-weight heparin (LMWH) as the preferred anticoagulant at discharge for AF patients. This preference is not supported by current guidelines, which only recommend the use of LMWH for specific situations such as prior to cardioversion.[19] Upon examination of the participants' responses, it was found that their preference for LMWH is rooted in the belief that it does not require drug level monitoring. Additionally, participants who prescribed LMWH at discharge of AF patients stated that the belief that patients would follow up increased their preference for OAC. LMWH was perceived as an alternative method that reduced concerns regarding follow-up in the cardiology outpatient clinic. However, despite these beliefs, participants acknowledged that LMWH is administered subcutaneously, is difficult for patients to self-administer, and can cause discomfort with repeated use, which highlights the advantages of NOACs.

In summary, barriers to emergency department physicians prescribing oral anticoagulant medication include the requirement for insurance coverage, uncertainty surrounding the monitoring of bleeding

risks, and the potential for biased treatment based on a patient's sociocultural background. These factors have led emergency physicians to employ strategies such as prescribing off-label medications like low-molecular-weight heparin, which may not be included in established guidelines. In order to address these issues, strategies such as the development of patient follow-up protocols, the establishment of appointment systems for these patients, and the widespread implementation of in-service training programs to ensure adherence to guidelines are necessary.

Limitations of the Study

The limitations of the semi-structured interviews with emergency physicians should be noted. The average duration of 20–25 minutes per interview may have resulted in some participants experiencing difficulty in maintaining concentration throughout the duration of the interview. Additionally, it is possible that individual physicians may have presented idealized or overly standard answers rather than their actual clinical practices. Furthermore, among the physicians participating in the study, only one had more than 20 years of experience, and the most experienced physician only had 15 years of experience, which may have limited the ability to analyze the responses of physicians with more than 15 years of experience. These factors may have impacted the validity of the results obtained from the interviews. One of the primary limitations of our study is the relatively small sample size, which may limit the generalizability of our findings to broader populations.

Conclusion

The initiation of oral anticoagulant drugs at the discharge of newly diagnosed AF patients by emergency medicine specialists is influenced by various factors. Adherence to guidelines specific to emergency medicine, which recommend the use of anticoagulants in the discharge of AF patients, may help to reduce variations in approaches among emergency physicians. This could be achieved through comprehensive developments, including improvements at the system level, the establishment of a diagnosis–intervention–prescription–follow-up chain, and the provision of educational opportunities for healthcare providers.

Ethics Committee Approval: The study was approved by Istanbul Medeniyet University Göztepe Training and Research Hospital Clinical Research Ethics Committee (No: 2021/0364, Date: 30.06.2021).

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