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Facilitators and Barriers for Implementation of Shared Decision Making: A Review

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ABSTRACT

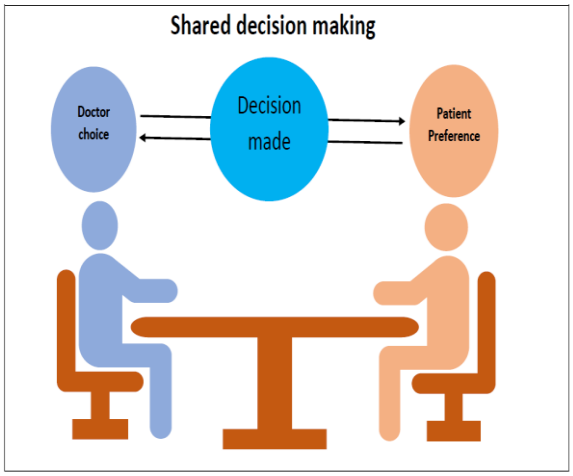
Shared decision-making is patient-centered Care that involves patients and health care professionals to decide treatment for patient condition mutually. Healthcare professionals have not widely adopted shared decision-making because some barriers/facilitators stop healthcare professionals from implementing shared decision-making in the same way some barriers/facilitators are preventing patients from involving in shared decision-making. Many studies have explained barriers/facilitators that stop patients/healthcare professionals from applying in SDM individually. The objective of the study is to examine the patient-related and healthcare professional's related barriers / facilitators to implementing SDM.

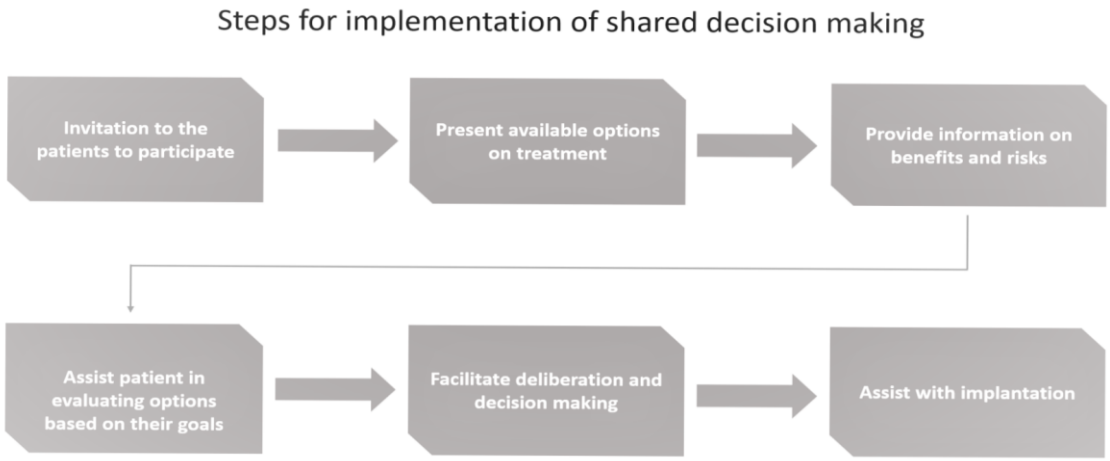
Keywords: SDM, Shared decision-making, barriers, facilitators

INTRODUCTION

Shared decision-making is a standard method where using the best available evidence, clinicians and patients make decisions together, helps to select the best course of action for them, patients are encouraged to think about the appropriate screening, treatment, or management options and the likely benefits and harms of each. [1] The concept of SDM is seen as a critical patient-centered component of Care and describes the importance of the patient's physician Relationship in health outcomes. [2] Shared decision-making depends on establishing a solid therapeutic relationship to exchange knowledge and assist patients in deliberating and sharing their interests and concerns during the decision-making process. [3] Care and kindness were once often the only "treatment" open to physicians. Over time, developments in medical research have created new options that have unwittingly distanced physicians from their patients, although they also enhance results. Patients and their families are frequently excluded from critical conversations and left feeling in the dark to solve these forms of issues that have been brought into therapy through shared decision-making. [4] Shared decision-making provides a systematic way to integrate facts into medical decision-making and patient beliefs and expectations. This process will promote discussions that lead to better-informed decisions aligned with what matters most to patients. Suppose they do not entirely understand their current health condition, treatment options, and the possible side effects of each treatment choice. The following phases are included in shared decision-making. A decision may require more than one visit a) Identify a clear decision point b) Provide information about the clinical problem and options at the

decision point. C) Elicit the patient perspective d) Guide the patient toward a final decision. e) Assess how comfortable the patient is with his or her decision. [5,6] Shared decision-making has earned wide range of acclaim for its clinical advantages and positive effects on patient involvement. It will rely on effective patient outreach to adopt a practical and patient-centered shared decision-making approach. [6] In shared decision-making (SDM), which is at the heart of patient-centered treatment, there has recently been an explosion of interest and research. SDM is a two-way mechanism in which both the patient and the clinician share evidence and the responsibility for decision-making. [7]





Patients perceived barriers and facilitators for implementation of shared decision making

Barriers	Facilitators
1. There is a lack of consistency in the treatment, side effects, and damage reversibility.	1. The need for precision, the use of numerical or predictive probabilities for success, holding options open, taking time to make a decision, and taking into account patient decision-making preferences.
2. Uncertainty in the making of choice, recommendations made	2. The ability to receive enough knowledge without being stressed, the physician's disposition (feeling cared for and trusted), and the use of family and friend experiences
3. Unsatisfactory voice-related QoL resulted in more decision-making conflict and regret.	3. Have faith in your doctor
4. Physicians making decisions for them, use of medical language in visits, changing groups of providers, lack of knowledge	4. The most significant element in the care decision was the first clinician seen.
5. Long narratives with no time for processing/questions, physician subject matter, directive/deferential speech	5. The presence of a caregiver during visits
6. In elderly patients, higher fatalism, communication quality, and provider involvement were reduced as their age increases.	6. Use open-ended questions, affirmations, and occasional breaks in your speech to make it more inviting.
7. Insufficient time for decision-making will lead to the disease becoming more worse.	7. A second party to assist in decision-making/ to be present during a meeting, joint or patient-centered decision-making, and supportive care beliefs (e.g., belief in reducing the risk of recurrence)
8. A lack of knowledge about what to ask, negative clinician attitudes.	8. Getting other people's advice and being concerned with the treatment's physical effects
9. Inadequate physician contact (> 30%) on ethical issues, medical needs, life support wishes, living wills, hospital proxy, and hospice treatment.	9. Mutual care, social support, questioning, obtaining a variety of facts, getting adequate responses, and making independent decisions
10. The fear of being diagnosed and treated.	10. Appropriate physician contact about physical symptoms, emotional symptoms, cure improvements, treatment problems, and treatment objectives
11. Clinicians who do not listen to or accept the needs or opinions of their patients.	11. Consistent informal assistance
12. Clinicians who believe that patients would instead not be involved in decision-making and do not need it.	12. Practitioners who listened to and valued the experiences of service users and caregivers.

Physician perceived barriers and facilitators for implementation of Shared decision making

Barriers	Facilitators	Barriers and facilitators
1. Unfamiliarity with the situation 2. Ignorance 3. Lack of time for patients to engage in the SDM process due to clinicians' busy schedules. 4. a scarcity of capital 5. Clinicians who conclude that patients would instead not be involved in decision-making and do not need it. 6. The patient didn't know what he was doing 7. Insufficient information 8. Unawareness	1. A feeling of anticipation 2. Working with the patient 3. provide adequate time for SDM implementation	1. Inquiring about the patient's role in joint decision-making 2. the time 3. insufficient capital 4. inability to obtain surveillance 5. patients sharing liability 6. patient's expectations 7. incapacity to judge 8. incompatibility 9. use-complexity 10. inability to be seen 11. inability to get paid 12. motivational deficits 13. cost-effective

Some of the common barriers and facilitators for the implementation of shared decision making

Environmental Factors	
Organizational factor	**Healthcare system factors**
1. The passing of time (bar and fac) 2. There are far too many physicians involved in patient care (bar) 3. Environmental conditions that aren't perfect (bar) 4. Resources are scarce (bar) 5. Encouragement in the use of decision aids (bar and fac) 6. Healthcare professionals' encouragement to incorporate SDM (bar and fac) 7. SDM consultations on several occasions (bar and fac) 8. SDM is triggered by an e-health record (fac) 9. SDM performance assessment and reviews (fac) 10. Non-physician staff (e.g., nurses, social workers) are involved (bar and fac)	1. Regulatory and policy framework (bar and fac) 2. SDM communication skills should be integrated into medical education (fac) 3. Incentivizing providers to participate in SDM through a payment model (fac)
Patient/Family Factors	
Patients' perceptions	**Patient capacity**
1. The belief that "the doctor is always right" (bar) 2. Not able to comprehend medical knowledge (bar) 3. Asking questions is appropriate (bar and fac) 4. Patients' participation is frowned upon by physicians (bar) 5. Acceptance of the fact that the medical encounter involves two experts (fac) 6. Recognizing and dealing with confusion and equipoise (fac) 7. Accepting the management of involvement (bar and fac) 8. In consultations, there is a lack of expectation for SDM (bar)	1. State of health (bar and fac) 2. Characteristics of Patients (bar and fac) 3. Lack of self-confidence (bar) 4. Parental participation is significant (fac) 5. Preferences and fears are two things that people have when it comes to making decisions. 6. Preferences for being a part of the process (bar and fac) 7. Fear the repercussions of being labeled as complex (bar) 8. Fear of receiving a diagnosis and having to recognize it (bar)
Relationship factors	**Factors related to information provision**
1. The relationship's consistency (bar and fac) 2. Have faith in your doctor (bar and fac) 3. The clinician is familiar with the patient or is unfamiliar with the patient (fac and bar) 4. Patients and clinicians have different personal characteristics (e.g., gender, language) (bar)	1. Talking about the preferences of the patients (bar and fac) 2. Listening to patients' Needs and Acknowledging their Views (bar and fac) 3. Checking for knowledge comprehension regularly (fac) 4. Explicitly allowing participation in SDM (bar and fac) 5. Patients aren't given clear options (bar) 6. Educating patients on treatment choices and results (bar and fac) 7. Using easy-to-understand terms (bar and fac) 8. Sharing accountability with the patient (fac) 9. Using decision support tools (fac)

Professional characteristics
1. Personality traits (bar and fac) 2. SDM isn't well-known (bar) 3. Make decisions in an authoritarian way (bar) 4. a decision-making style that is shared (fac) 5. Behavioral patterns (bar) 6. Expert opinion(bar) 7. Patients tend not to be active and do not need it, according to this perspective (bar) 8. Recognizing patients' desire to engage in decision-making and their obligations to do so (bar and fac) 9. Patient outcomes and the healthcare process are projected to improve as a result of SDM (fac) 10. Aspects of SDM that have been agreed upon (bar and fac)

Importance of shared decision making in clinical practice:

Patients can gain confidence in their caregivers by using shared decision-making strategies, and providers can connect and interact with their patients more effectively. [31] According to research, patients who are given the power to make healthcare choices that match their interests report feeling more

involved in their care and having improved health outcomes, such as reduced anxiety, faster recovery, and greater adherence to treatment regimens. [32] The use of decision aids decreased the number of patients who were passive in their care and improved patient adherence to prescribed treatments. Patients also had more information, more realistic perception of risk, and less internal tension when it came to healthcare decisions. [33] SDM remains a valuable tool for promoting patient autonomy and satisfaction due to its positive interaction with patient outcomes. [34] Health outcomes and the patient experience will also benefit from shared decision-making. [35]

CONCLUSION

Overall, there were strong themes in this study about the barriers and facilitators to implementing SDM in health care. These characteristics may help develop a straightforward SDM plan for clinical care, including treatments and decision aids, by considering patients' principles when making treatment decisions and maximizing training opportunities for medical professionals involved in health care delivery.

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