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Review

Physician attitudes toward shared decision making: A systematic review

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ABSTRACT

Objective: Although evidence suggests that shared decision-making (SDM) can improve patient outcomes, uptake to date has been sparse. The purpose of this review was to determine the reported opinions of physicians regarding the use of SDM in clinical practice and to identify strategies to promote uptake.
Methods: We conducted a systematic review, including papers published between 2007 and 2014.
Results: The electronic search yielded 11,761 results. Following abstract review, 123 papers were selected for full text review, and 43 papers were included for analysis. Fourteen of the included studies considered SDM within the context of primary care, 25 in secondary care, and 4 in both.
Conclusions: Physicians express positive attitudes toward SDM in clinical practice, although the level of support varies by clinical scenario, treatment decision and patient characteristics.
Practice implications: Physician support for SDM is a necessary, if not sufficient, condition to facilitate meaningful SDM. In order to garner support for SDM, additional empirical evidence regarding the clinical and patient important outcomes must be established. Based on the results of this review, the authors suggest assessing the impact of SDM within the context of chronic disease management where multiple therapeutic options exist, and outcomes may be measured long-term.

Contents

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1. Introduction

Over the past 2 decades, there has been a shift in support away from a paternalistic model of clinical decision making towards an approach wherein the patient takes on a more central role, and decisions are reached in partnership between patient and physician [1]. We adopt the definition of SDM put forth by Charles et al. wherein a truly shared approach requires that both the physician and patient be involved in the decision-making process and information exchange, both the physician and the patient express treatment preferences, and finally, the physician and patient agree on treatment decision [1,2]. Charles and colleagues initially focused their conception of SDM specifically on treatment decisions, but it has been broadened to include a range of health care decisions such as disease management and screening.

Improvements in access to health information and treatment options have facilitated a patient–physician relationship that allows for a more active partnership. Decision making has also become more complex, with a variety of treatments available that carry different risk profiles as well as uncertainties related to outcomes, adverse events and quality of life [3]. In the presence of uncertainty regarding the optimal treatment option, the involvement of patients in their healthcare and treatment decision making is increasingly important [4]. Related to this is the opinion that SDM may be most appropriate or garner the highest levels of support in scenarios where clinical equipoise are present [5,6].

SDM has been placed at the forefront of much public and academic discussion in recent years, and efforts have been made to promote patient/physician communication within the clinical and policy sphere [7,8]. Although support for a shared approach has become popular in the academic and policy literature, such a shift to a more patient-centered approach has been slower. To date, SDM within the context of clinical practice has been minimal [9,10]. Previous research suggests that lack of implementation may be due to barriers such as the time required to incorporate patients into the decision making process, physicians' perceptions that the specific clinical scenario is inappropriate for SDM, or physicians' perceptions that the patient may be unwilling or unable to participate in the decision [9].

Proponents of SDM argue that the more a patient is involved in the treatment decision at hand, the more likely it is that the decision will be consistent with his or her own personal preferences [11]. Particularly for treatment scenarios where there is no "correct" answer or best treatment option, the most appropriate choice is arguably that which is consistent with the patient's lifestyle, living situation, goals and personal preferences. Previous research investigating outcomes associated with SDM has shown that many patients wish to be involved in the decision making process and, that doing so may increase patient satisfaction with care and satisfaction with treatment decisions [12–15]. Limited evidence exists regarding the clinical outcomes associated with SDM as measured by empirical experimental evidence. However, recent review work regarding the implementation of SDM has shown that SDM may reduce healthcare utilization and costs, improve treatment adherence, patient function, as well as improving additional clinical outcomes [15–17].

Attempts to determine physicians attitudes toward SDM has focused on health care professionals' perceived barriers and facilitators to incorporating SDM into their practice [9,18]. Physician reported barriers include but are not limited to insufficient time, physician perceptions that the patient may be unable or unwilling to participate, as well as the opinion that SDM is inappropriate given the decision context. Frequently cited facilitators include physician perceptions that the patient has adequate emotional support systems, the perception that SDM will lead to a positive impact on patient outcomes, patient knowledge, trust in their physician, as well as physician willingness to participate in the decision making process [19,20].

Since the implementation and the success of SDM is largely dependent on active engagement of the treating physician (and care team), we consider it important to determine the overall level of support for SDM that exists among physicians. More specifically, this review seeks to determine to what extent physicians currently support the implementation of SDM to routine practice, and which clinical contexts garner the highest levels of support. This review goes beyond an assessment of physician reported barriers and facilitators to implementing SDM, to address which clinical scenarios garner the highest levels of physician support. The results of this review provide further evidence to explain why physicians tend to hold certain views toward SDM, and why resistance to SDM in certain care scenarios may exist. Our work represents the first comprehensive systematic review of the literature on this topic.

2. Methods

2.1. Search strategy development

SP developed the search strategy, in consultation with a research librarian (see Fig. 1). The complete search was initially developed in Medline and then adapted to each subsequent database. SP executed the searches between December 19th and 23, 2014. The following databases were searched from 2007 to current: Medline, Embase, CINAHL, Cochrane database of randomized controlled trials, and PsychInfo. Following the search of electronic databases and article selection, references of included studies were also reviewed. This review was limited to published and peer reviewed literature. Publication bias was not formally assessed.