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Short communication

Shared decision-making in physical therapy: A cross-sectional study on physiotherapists' knowledge, attitudes and self-reported use

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ABSTRACT

Objective: This study aimed a) to investigate knowledge, attitudes, and self-reported use of shared decision-making (SDM) among physiotherapists in Germany, b) to explore their association with demographic characteristics, and c) to assess barriers to the implementation of SDM.
Methods: We assessed above mentioned domains using an online survey. Two-level logistic regression models were used to examine factors associated with knowledge, attitudes and self-reported use of SDM.
Results: 60.5% of a total sample of 357 participants reported to have had no knowledge on SDM before participating in the survey. Attitudes towards SDM were mostly positive, half of all participants expressed a preference for SDM. About two thirds of all participants reported to use a rather paternalistic approach in routine care. Knowledge, attitudes, and self-reported use of SDM were associated with several demographic characteristics.
Conclusion: SDM was perceived as an appropriate concept in physiotherapy. However, missing knowledge and limited self-reported use of SDM in routine care on the one hand and positive attitudes towards SDM on the other hand indicate a need for action.
Practice implications: In order to emphasize the use of SDM in physiotherapy efforts need to be undertaken in research, clinical practice and health policy.

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1. Introduction

Shared decision-making describes a conjoint decision-making process in health care in which clinician and patient are actively involved [1,2]. The SDM process includes the exchange of medical information and patient preferences, and the clinician's active support in balancing benefits and risks of treatment alternatives [3,4]. It is particularly relevant if different treatment options are available and similarly suitable [5,6].

So far, SDM has mainly been investigated in patient-physician interactions. Research on the adoption of the concept to other clinical fields such as physiotherapy is limited. Few existing studies suggest that SDM could be suitable in physiotherapy [7–10], which is also reflected in a range of international clinical guidelines [11–16]. However, it is not found to be well implemented in routine care [7–10].

Unlike many other countries, physiotherapy in Germany is prescribed by the physician [17]. Nevertheless, the majority of prescriptions from physicians gives leeway to the physiotherapist to offer different treatment options to their patients [18,19]. To our knowledge, no study has explored SDM in German physiotherapy so far.

The aims of this study were to assess a) German physiotherapists' knowledge, attitudes, and self-reported use of SDM, b) their association with demographic characteristics and c) barriers to the implementation of SDM. This study aims to provide an overview of perceptions of physiotherapists with diverse career pathways working in various clinical settings.

2. Methods

We recruited physiotherapists through the largest national association of physiotherapists in Germany (consisting of 13 federal associations with approximately 26,000 members) [20].

Inclusion criteria for participation were i) living in Germany, ii) licensed as nationally recognized physiotherapists, and iii) currently working as physiotherapists. Each participant provided electronic informed consent prior to study participation.

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The online survey was developed using a multi-step process, comprising a literature search on relevant existing surveys and measures, the creation and revision of the first survey version within a multidisciplinary research team and a pre-test using cognitive interviews (N = 5) [21].

The final online survey (Supplementary Appendix A) consisted of 48 items assessing five domains: 1) knowledge on SDM, 2) attitudes towards SDM, 3) self-reported use of SDM, 4) barriers to SDM, and 5) demographic characteristics. Adaptations of the Control Preferences Scale (CPS) [22] and the SDM-Q-Doc [23] were included in the survey. The barriers section was informed by previous research [24,25].

Cross-sectional data was collected in June and July 2016. Ten of 13 federal associations agreed to invite their members to the survey by email (no reminder was sent); two additional federal associations placed an invitation on their website.

Only participants who completed the entire survey were included in the analyses. We assessed completion rate by comparing the number of participants who agreed to participate (i.e. gave informed consent) to the number of participants submitting the final survey page. Due to the indirect sampling method, it was not possible to calculate exact response rates.

For analyses, the five response options of the adapted CPS were merged into three categories: a) *(rather) paternalistic* (i.e. clinician-led decision-making) b) *shared* (i.e. SDM) or c) *(rather) informed* (i.e. patient-led decision-making). Additionally, we used the Wilcoxon signed rank test to detect differences between attitudes and use of SDM based on the answers on the CPS.

We calculated descriptive statistics for knowledge, attitudes, use of SDM, the relevance of barriers, and demographic characteristics. We used three two-level mixed logistic regression models with listwise deletion to identify statistical associations between demographic characteristics and the outcome variables. Hosmer-Lemeshow tests assessed the goodness of fit.

Regarding knowledge, the 11-point Likert scale (0 = no knowledge, 10 = comprehensive knowledge) was transformed into a dichotomous variable (i.e. *no knowledge* vs. *some knowledge*). Regarding attitudes and use, only the categories *(rather) paternalistic* and *shared* were included in the regression models; *(rather) informed* was excluded, due to $N < 20$ participants who chose this category.

The following independent variables were included in the regression models: 1) length of professional experience, 2) sex, 3) type of professional training, 4) working hours per week, 5) average length of a treatment session, 6) work setting, and 7) to 11) five different typically treated patient groups (treated: *yes* vs. *no*). In a second step, the remaining two outcome variables were included in each regression analysis. Tests were considered statistically significant at $p < 0.05$. Analyses were conducted using IBM SPSS Statistics, version 21 (IBM Corp, Armonk, New York).

3. Results

Of 629 participants who agreed to participate, 357 (56.8%) completed the survey and were included in the analyses. 264 participants did not complete, and eight did not meet the inclusion criteria. Demographic characteristics are described in Table 1.

216 (60.5%) participants stated that they did not know anything about SDM. Answers ranged from 0 = no knowledge to 10 = comprehensive knowledge, with a mean of 1.8 (SD = 2.8). 163 participants (45.7%) preferred a (rather) paternalistic approach, 178 (49.9%) favored SDM, and 16 (4.5%) a (rather) informed approach. 242 participants (67.8%) reported that they typically use a (rather) paternalistic approach, while 103 (28.9%) stated to use SDM in routine care (Fig. 1). There was a significant difference between attitudes towards different decision-making approaches and their use ($Z = -7.34$; $p \leq 0.001$). Results regarding attitudes and use of SDM in different patient groups and a more detailed view on use of SDM based on the adapted SDM-Q-Doc are presented in Supplementary Appendix B (Table B1 and B2).

Table 1
Demographic characteristics of the study participants.

	N = 357[a]	%
Sex		
Female	270	75.6
Male	86	24.1
Age		
Mean (SD, range)	45.0 (11.0, 21–68)	–
Highest degree		
Vocational training	276	77.3
Bachelor	51	14.3
Master	29	8.1
Work setting[b]		
Private practice (outpatient)	285	80.3
Hospital (inpatient)	44	12.4
Therapy center (outpatient)	34	9.6
Rehabilitation center (inpatient)	27	7.6
Patient groups treated[b]		
Patients with chronic musculoskeletal conditions	323	91.0
Patients with acute musculoskeletal conditions	316	89.0
Patients with neurological disorders	254	71.5
Geriatric patients	208	58.6
Professional athletes	182	51.3
Pediatric patients	96	27.0
Patients with cardiovascular diseases	94	26.5
Patients with mental disorders	70	19.7
Length of professional experience (in years)		
Mean (SD, range)	20.7 (11.2, 0–46)	–
Working hours per week		
Mean (SD, range)	33.7 (11.2, 4–65)	–
Average length of a treatment unit (in minutes)		
Mean (SD, range)	26.4 (6.9, 15–60)	–

In the two-level regression analysis predicting knowledge on SDM (Table 2), we found physiotherapists with an academic degree (compared to vocational training) to be more likely to have knowledge on SDM. Furthermore, physiotherapists with longer professional experience were less likely to report knowledge on SDM.

Table 3 shows that female physiotherapists were more likely to prefer SDM than males. More self-reported use of SDM was significantly associated with more positive attitudes towards SDM. The inclusion of self-reported use of SDM in the second step of the model increased the explained variance from 13% to 41%.

Self-reported use of SDM was associated with length of professional experience. Physiotherapists with longer experience were more likely to report using SDM. We found similar associations for attitudes and use of SDM as described in the second model; explained variance increased from 12% to 44% (Table 4). Knowledge on SDM was associated neither with attitudes nor with use of SDM.

In all three models, the treatment of particular patient groups was associated with the outcome variables.

Participants reported instructions given by the physician, time constraints, and the perception that patients do not want to be involved as the most relevant barriers to SDM in physiotherapy (Table 5).

4. Discussion and conclusion

4.1. Discussion

This survey explored physiotherapists' knowledge, attitudes, and self-reported use of SDM as well as perceived barriers to the implementation of SDM. Key findings were that knowledge on the

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