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Abstract

Background: Shared decision-making is advocated as a key component of patient-centred care and associated with many benefits that improve patient outcomes. However, shared decision-making is not yet embedded in clinical practice and confronts many barriers that hinder its implementation especially in countries of the World Health Organization (WHO) Eastern Mediterranean Region.

Aims: We conducted a systematic review to identify and understand factors influencing shared decision-making in the Region.

Methods: We searched PsycINFO, CINAHL, PubMed, Medline, Scopus and Saudi Digital Library for articles published between January 1997 and February 2019. Studies conducted in the Region that reported barriers, facilitators, experiences, expectations and attitudes to shared decision-making were included. The Mixed Methods Appraisal Tool (MMAT) was used to assess the methodological quality of the studies in this review.

Results: Of the 1813 initial articles retrieved, 19 eligible articles were identified. The main factors that emerged were grouped under three broad themes: participant factors (patients/families and physicians); consultation factors (relationship between participants, engaging patients, evaluating preferences, introducing options, providing information, and decision making); and healthcare system factors (organizational characteristics, time constraints, continuity of care, and healthcare resources).

Conclusions: There is growing interest in shared decision-making in several countries in the Region. However, there are many existing barriers that hinder the implementation of shared decision-making. These need to be addressed before shared decision-making can be fully adopted in these countries.

Keywords: shared decision-making, Eastern Mediterranean Region, barriers, facilitators, implementation.

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Introduction

Shared decision-making (SDM) is an approach in which physicians and patients work jointly, utilizing the best available evidence, to make decisions that considers the patients' preferences (1). SDM is considered to be a key component of patient-centred care and corroborated in high-level policy in developed countries (2,3). Patients and clinicians in western and nonwestern countries show positive attitudes and preferences toward SDM

(4–6). According to The Health Foundation (7), there is robust evidence of benefits from implementing SDM. These include greater treatment adherence, better patient confidence and coping skills, and reductions in the demand for major surgical interventions.

There is also a large and growing body of literature on the factors that influence SDM and its implementation, and many reviews have been conducted that provide comprehensive evidence on this topic (8–11). However, most of the reviews in the literature are from high-income settings, predominantly in western countries. Little is known about SDM in the World Health Organization (WHO) Eastern Mediterranean Region and it is not clear which factors may hinder or facilitate the implementation of it in these countries. Similarly, in many of the high-income western countries, the concept of patient-centred care or SDM is being integrated into health systems, but this is not yet the case in the Region and other developing countries.

The Region comprises 21 countries as defined by WHO (12). Despite some cultural similarities (Islamic culture) and commonalities in historical background, there is also a high degree of diversity when it comes to developmental profiles and socioeconomic conditions that invariably affects the maturity of health systems and population health status in the different countries in the Region (13). Notably, the Region includes high-middle-, lower- and lower–middle-income countries (14). Moreover, the culture, social context, and health sector leadership and governance in these countries are different to those in western countries. If the desired aim is to promote and facilitate the integration of SDM into existing healthcare systems in the Region, there is a need to investigate and better understand the perception of SDM and challenges of implementing SDM in these countries. Therefore, we carried out a systematic review of the literature that sought to identify and understand the factors influencing SDM in the Region.

Methods

Search strategy

The following databases were searched for relevant articles published between 1997 and February 2019: PsycINFO, CINAHL, PubMed, Medline, Scopus, Saudi Digital Library, Open Grey, EThOS, Social Care Online. The search included other sources such as reference lists of included studies and articles citing the included studies. The searches were not restricted by language and relevant articles were translated into English. The search terms were built with help from one of the information specialists. We searched for articles on SDM or related concepts such as “patient engagement”, “patient-centred care”, “patient activation”, “decision support” and “decision aids”. Full details of the search strategies in (Medline, PsycINFO, CINAHL, Scopus and PubMed) can be found in Supplementary File 1. Other electronic databases were searched using keywords from the search strategies.

Inclusion criteria

The eligible studies were all qualitative, quantitative, or mixed-method studies that mentioned SDM or associated terms. Participants included were patients, families, healthcare and medical professionals, facility managers, and policy-makers. The intervention was SDM or its tools, such as decision aids, as they are tools often used in the SDM process. Studies were included if they reported perceptions, barriers, facilitators, experiences, expectations or attitudes to SDM. All

healthcare settings in countries in the WHO Eastern Mediterranean Region were included.

Study selection

Electronic search results were exported to reference management software (Mendeley) and duplicated records were identified and excluded. Two reviewers (NA and TA) screened the titles and abstracts, and then full-text articles for exclusion or possible inclusion. Any uncertainty over inclusion of any article was resolved through discussion with researchers PT and AL and agreed by consensus.

Data extraction and quality assessment

One reviewer (NA) extracted data and assessed the quality of the included studies. The other reviewer (TA) verified the accuracy of the data extraction and quality assessment of all the included studies. Data were abstracted using a data extraction sheet developed specifically for this review. The variables extracted were: country of origin, healthcare setting, methodology and design of study, data collection tools, participants and sample size, aim of study, influencing factors, and type of results (Table 1). The Mixed Methods Appraisal Tool (MMAT) version 2018 (15) was used to assess the methodological quality of the studies. MMAT is a validated tool for appraising primary qualitative, quantitative and mixed-methods studies for systematic reviews. Although MMAT did not propose a scoring system, we categorized reviews as “good” when 6 or 7 of the criteria were achieved, “moderate” when 3–5 of the criteria were achieved, or “poor” when 0–2 of the criteria were achieved.

Data synthesis

Narrative synthesis was used to synthesize the findings from multiple studies in the review, using words and text to summarize and explain the key findings (16). This approach was chosen due to the heterogeneity of study designs, study populations, types of factors, and study contexts. Study characteristics were extracted to describe the main features of each study (Table 1). The data extracted were compiled and key themes were subsequently identified and categorized.

Ethical approval

Ethical approval was not required.

Results

Study selection

The study selection process is summarized in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Figure 1). The searches yielded 1813 references. After removing duplicates, there were 1201 unique articles, and 1172 were then excluded after screening by title and abstract. Of the remaining 29 full-text articles retrieved, 19 eligible articles were identified. The main reasons for exclusion included: studies did not mention SDM; focus on the purpose of the written informed consent; patients' views were on a specific decision, such as decision-making for antenatal screening, and not about the shared approach; or focus on how emergency physicians decide and assess the process of using clinical decision-making.

Study characteristics

An overview of the 19 included studies is presented in Table 1 . They were from Islamic Republic of Iran, Saudi Arabia, Jordan, Oman, Morocco, Egypt and Pakistan. All were in English except for one in French (17).

Study participants included clinical staff (doctors and nurses), and patients and their family members. The study settings covered public, private and teaching hospitals, of which half were from teaching hospitals. Seven studies were from oncology units. The remaining studies were from other clinical settings: rehabilitation, neurology, dentistry, rheumatology, orthopaedics, anaesthesia, urology, gynaecology, emergency medicine, general internal medicine, and general surgery.

In terms of type of results, two studies assessed the role of family in the treatment decision-making process (18,19). Seven studies reported patients' perspectives, participation, preferences, beliefs and knowledge (4,5, 17,20–23). Five studies reported physicians' perceptions, attitudes and experiences (24–28). Four studies explored experiences, perceptions and preferences of both patients and clinical staff (29–33).

In terms of the aims of the studies, two sought to determine physicians' and patients' perspectives on barriers to and facilitators of the use of patient decision aids (27, 29). Two other studies assessed the role of family members in treatment decision-making and factors that influenced that decision (18,19). The other studies reported on factors influencing physicians' and patients' preferences with regards to SDM. Only one study explored the process of decision-making by physicians and their patients during consultations (33).

Fifteen studies used a quantitative approach (mainly involving questionnaires). A qualitative

approach was used in two studies (26,29) and in one thesis (33). A mixed-methods approach was used in another thesis (30).

Table 2

Quality assessment

All of the included studies performed well in MMAT except for two that performed moderately (31,32). The qualitative and mixed-methods studies met all of their criteria. However, the majority most of the quantitative studies were limited by use of convenience or purposive sampling techniques or small sample size (See Supplement 2).

Discussion

This review identifies several influential factors for SDM in the Eastern Mediterranean Region that include physician, patient and family member perspectives. These factors span the individual participant's role in decision-making, current SDM practices during clinical consultations, and SDM at the system level. However, the studies were from only seven countries. This indicates that SDM is not widely practised in countries in the Region as most developing countries have not integrated the concept of person-centred care into their health systems (34).

Unsurprisingly, patient and physician characteristics, such as their prior knowledge, experience and perceptions of SDM, and preferences towards it, are influential in determining whether it is practised. However, the practice of SDM is also affected by the attitudes of family members and the degree of their involvement in the decisions. These factors affect the interactions between the physicians and patients, as well as the consultation process including patient engagement, information provision and option sharing, elicitation and evaluation of patient preferences, and eventual decision-making. System-level factors also play a part such as time pressures, availability of healthcare resources to support SDM, and the degree of continuity of care provided. Figure 2 represents the relationship between these factors.

The most frequently cited factor was patients' level of education. Similar findings were previously reported in other studies from western countries (35,36). Patients' age was also a determinant in the Region, with a notable preference for a passive role with increasing age. Although this mirrors a study from Japan (47), this age factor is not consistent worldwide. For example, one American study found that older people wanted to share their medical decisions or make their own (37). In the Region, older patients may lack clinical knowledge and have

lower levels of education overall, which may explain the tendency towards adopting passive roles in decision-making (4,18–20).

This review found patient gender preferences for SDM. Al-Bahri and colleagues stated that family structures are more likely to be hierarchical in Middle Eastern culture (18). Traditionally, male family members such as husbands, fathers, and eldest sons have more authority in decision-making and therefore often dominate the decision-making process (38). This may explain the positive attitudes that male participants have towards decision-making. However, our review found that this trend was not universal and further exploration of the role of gender in decision-making is warranted, particularly as gender norms in the Region continue to evolve.

The quality of the physician–patient relationship is clearly vital and the behaviour of physicians is a key facilitator of patient trust (39). Linked to this is the adequacy of information provision as an enabler for SDM (40). Patient trust was boosted when physicians provided patients with a significant amount of information about their condition, test results, and adverse effects of different treatment options (39). However, patients' preferences for the amount of information provided differs among patients, and physicians need to tailor what information is exchanged with their patients. Key considerations include: the amount of prior knowledge that the patient has; how much information is considered to be sufficient; and who should decide if this information is enough for decision-making (41). An assessment of the level of patient understanding of the information provided is needed as there are variations in patients' health literacy.

Family involvement can facilitate patient participation in SDM and enhance this process. Family involvement can increase the probability for patients to experience positive emotions, and decrease the likelihood of them experiencing stress and uncertainty when making decisions about their condition (42). There are commonalities in the culture in the Region which has a collective nature and is family-centred. The families feel a moral responsibility for their members who are patients, and believe that they should be involved in the decision-making process (43,44). That said, this is not unique to the Region and has been reported in other cultures where family involvement in the decision-making process enhances patients' engagement and autonomy (45). However, family involvement can also be a barrier to patient participation when the family dominates the decision-making process. Family involvement may disrupt communication between patients and physicians, and may delay treatment decisions where there are conflicting views (46). This raises the question of how best to include family members in the decision-making process.

A key limitation of this review is the diversity of the countries included in the Region, ranging

from high-income countries like Saudi Arabia to more resource-constrained settings such as Pakistan. There are significant resource, socioeconomic and health system differences, as well as variations in demographic profiles. Moreover, the studies included did not cover all countries in the Region, and there were not many studies on SDM in the Region. Consequently, the aggregated findings in this review may not be truly representative or readily generalized to all countries in the Region. This highlights a need for further country-specific research into local SDM practices and determinants.

The implementation of SDM in any setting is subject to a complex landscape of interacting barriers. These need to be identified and addressed to ensure effective implementation, and can be enhanced through utilizing known facilitators. Much of the focus previously has been on physician factors, but as this review shows, there is a need to also address patient factors, family involvement, as well as wider health system issues. The development of simple patient decision aids that could be understood by patients with low literacy levels could be efficacious. Encouraging clinicians to provide patients with more tailored information is also key, but this will require resourcing such as the provision of more consultation time. We need more research that considers cultural norms and the organizational and health system perspective, as well as SDM research in other countries in the Region where little has been done so far. Future research into these aspects is warranted.

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Opinions des parties prenantes sur les facteurs influençant la prise de décision

partagée dans la Région de la Méditerranée orientale : analyse systématique

Résumé

WHO EMRO | Views of stakeholders on factors influencing shared decision-making in the Eastern Medite

Contexte : La prise de décision partagée est préconisée en tant que composante clé des soins centrés sur le patient et associée à de nombreux avantages qui améliorent les résultats pour ces derniers. Toutefois, ce mode de prise de décision n’est pas encore intégré dans la pratique clinique et se heurte à de nombreux obstacles qui entravent sa mise en œuvre, en particulier dans les pays de la Région de l’Organisation mondiale de la Santé (OMS) pour la Méditerranée orientale.

Objectifs : Réaliser une analyse systématique afin d’identifier et de comprendre les facteurs influençant la prise de décision partagée dans la Région.

Méthodes : Nous avons cherché des articles publiés de janvier 1997 à février 2019 dans PsycINFO, CINAHL, PubMed, Medline, Scopus et la bibliothèque numérique saoudienne. Les études menées dans la Région qui faisaient état des obstacles, des éléments favorisants, des expériences, des attentes et des attitudes vis-à-vis de la prise de décision partagée ont été incluses. L’outil d’évaluation des méthodes mixtes (MMAT) a été utilisé pour évaluer la qualité méthodologique des études de cette analyse.

Résultats : Sur les 1813 articles initiaux récupérés, 19 articles éligibles ont été identifiés. Les principaux facteurs qui ont émergé ont été regroupés en trois grands **thèmes** : les facteurs associés aux participants (patients/familles et médecins) ; les facteurs de consultation (relation entre les participants, engagement des patients, évaluation des préférences, introduction des options, fourniture d’informations et prise de décision) ; et les facteurs liés au système de santé (caractéristiques organisationnelles, contraintes temporelles, continuité des soins et ressources sanitaires).

Conclusions : Plusieurs pays de la Région s’intéressent de plus en plus à la prise de décision partagée. Cependant, il existe de nombreux obstacles qui entravent la mise en œuvre de ce mode de prise de décision. Il faut s’attaquer à ces problèmes avant que la prise de décision partagée puisse être pleinement adoptée dans ces pays.

آراء أصحاب المصلحة المعنيين بشأن العوامل المؤثرة على عملية اتخاذ القرار المشترك في إقليم شرق المتوسط : استعراض منهجي

نوف السلمي، أندرو لي، برافين ثوكالا، تركيه العيسى

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WHO EMRO | Views of stakeholders on factors influencing shared decision-making in the Eastern Medite

الخلاصة :

: يُشار إلى عملية ااتخاذ القرار المشترك بوصفها أحد المكونات الرئيسيةالخلفية للرعاية التي تركز على المرضى، كما أنها مرتبطة بالعديد من المنافع التي من شأنها تحسين المخرجات الخاصة بالمرضى . إلا أن عملية اتخاذ القرارالمشترك لم تُدمج بعد في الممارسات السريرية، وتواجه العديد من العقبات التي تحول دون تنفيذها، لا سيما في بلدان إقليم منظمة الصحة العالمية لشرق المتوسط .

: هدفت هذه الدراسة إلى استعراض منهجي لتحديد العوامل المؤثرة على عملية اتخاذالأهداف القرار المشترك في الإقليم وفهمها .

: لقد نظرنا في (PsycINFO) (CINAHL) (PubMed) (Medline) (Scopus) والمكتبةطرق البحث الرقمية السعودية بحثاً عن المقالات التي نُشرت في الفترة بين عام يناير / كانون الثاني 1997 وفبراير / شباط 2019. كما أُدرجت الدراسات التي أُجريت في الإقليم وأفادت وجود عقبات أمام عملية اتخاذ القرار المشترك وعوامل مُيسّرة وتجارب وتوقعات ومواقف مرتبطة بها . واستُخدمت أداة تقييم طرق البحث المختلطة (MMAT) لتقييم الجودة المنهجية للدراسات المُتضمنة في هذا الاستعراض .

: من بين 1813 مقالاً مبدئياً من المقالات التي حُصل عليها، حُدد 19 مقالاًالنتائ ج صالحاً للاستخدام . وقُسمت العوامل الرئيسية التي ظهرت إلى 3 موضوعات عامة، ألا وهي : العوامل الخاصة بالمشاركين (المرضى / الأسر والأطباء) ؛ والعوامل الخاصة بالتشاور (العلاقة بين المشاركين، اشراك المرضى وتقييم التفضيلات، وتقديم الخيارات، وتقديم المعلومات، واتخاذ القرارات) ؛ والعوامل الخاصة بنظام الرعاية الصحية (الخصائص التنظيمية، والقيود الزمنية، واستمرارية الرعاية، وموارد الرعاية الصحية).

: هناك اهتمام متزايد بعملية اتخاذ القرار المشترك في عدة بلدان فيالاستنتاجات الإقليم . ولكن، لا يزال هناك العديد من العقبات القائمة التي تحول دون تنفيذ عملية اتخاذ القرار المشترك . وينبغي التصدي لهذه العقبات قبل اعتماد عملية اتخاذ القرارالمشترك اعتماداً تاماً في هذه البلدان .

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