The educational needs of primary care physicians regarding integration of shared decision making in daily practice

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Abstract (ENG)

Background: Shared decision making (SDM) is vital for patient-centered care, but general practitioners (GPs) and GP trainees (GPts) lack tailored educational resources for its effective implementation.

Objective: Identifying the educational needs regarding SDM for GPs and GPts to optimize educational purposes to enhance training programs and improve clinical practice.

Methods: A qualitative study was conducted using semi-structured focus group interviews with 12 general practitioners and 13 general practitioner trainees.

Results: Data analysis identified several educational needs which can be linked to four main themes: (1) Definition of SDM and its importance, (2) Implementation of SDM in daily practice and its use, (3) Teaching SDM generally, thoroughly, repeatedly and reflectively, (4) Time constraints of physicians and ways to bypass this.

Conclusion: General practitioners and general practitioner trainees expressed the need for continuous attention for SDM during medical school and during postgraduate medical education. They mentioned the need for all medical students to gain more theoretical insight early on, which could further enhance the process of SDM training. Applicable, tangible tools to facilitate the implementation of SDM should be further optimized and should be made easily accessible. With experience in SDM and accessible tools for SDM implementation, physicians could be equipped to address barriers such as time constraints and navigate specific challenging situations more effectively.

Abstract (NL)

Achtergrond: Gedeelde besluitvorming (SDM) is essentieel voor patiëntgerichte zorg, maar huisartsen (GPs) en huisartsen in opleiding (HAIO's) hebben gebrek aan op maat gemaakte educatieve trainingen voor effectieve implementatie ervan.

Doel: Het identificeren van de educatieve noden met betrekking tot SDM voor huisartsen en HAIO's om educatieve doeleinden te optimaliseren, gericht op het verbeteren van trainingsprogramma's en implementatie in de klinische praktijk.

Methoden: Er werd een kwalitatief onderzoek uitgevoerd door middel van semigestructureerde focusgroep interviews met 12 huisartsen en 13 huisartsen in opleiding.

Resultaten: Data-analyse identificeerde verschillende onderwijsbehoeften die gekoppeld kunnen worden aan vier hoofdthema's: (1) Definitie van SDM en het belang ervan, (2) Implementatie van SDM in de dagelijkse praktijk en het gebruik ervan, (3) Het onderwijzen van SDM in het algemeen, grondig, herhaaldelijk en reflectief, (4) Tijdgebrek van artsen en manieren om dit te omzeilen.

Conclusie: Huisartsen en huisartsen in opleiding gaven aan behoefte te hebben aan continue aandacht voor SDM tijdens de medische opleiding en tijdens de postdoctorale medische opleiding. Ze noemden de noodzaak voor alle medische studenten om al vroeg meer theoretisch inzicht te krijgen, wat het proces van SDM-training verder zou kunnen verbeteren. Toepasselijke, tastbare hulpmiddelen om de implementatie van SDM te vergemakkelijken moeten verder worden geoptimaliseerd en moeten gemakkelijk toegankelijk worden gemaakt. Met ervaring in SDM en toegankelijke hulpmiddelen voor SDM-implementatie zouden artsen uitgerust kunnen zijn om barrières zoals tijd te hanteren en om specifieke uitdagende situaties het hoofd te kunnen bieden.

1. Introduction

Shared decision making (SDM) is increasingly advocated as the ideal model for making medical decisions in clinical practice when there is more than one medically acceptable option to ensure that medical care aligns with the preferences and values of the patient.(1, 2) Several models for the practical application of SDM have been proposed. One such way to apply SDM is by using the "three-talk model" which consists of the team talk, the option talk and the decision talk.(3) In the team talk, patient and physician work together as the physician describes the choices, offers support and asks about goals and core values of the patient. During the option talk, alternatives are discussed using risk communication principles. Lastly, the decision talk focuses on the patient's informed preferences in order to make preference-based decisions.(3) The goal of SDM is to arm each participant with a better understanding of the relevant factors and share responsibility in the decision making process in order to provide optimal care.(4, 5) Optimally, the doctor and the patient decide together.(5)

In recent years, there has been an advance in studies that gauge the importance of SDM in day-to-day practice.(1, 6) Research has shown that application of SDM can lower decisional conflict and fewer patients are undecided or passive in the decision-making process. Patients experience less anxiety, stress and disappointment concerning their healthcare decision process. Patient engagement also increases patient knowledge, improved patient's health outcomes, patient adherence to treatment and shows generally a greater alignment of care with the patient's values.(7-10) Moreover, research illustrates that SDM could be used to reduce costs, as invasive surgical options were chosen around 20% less than more conservative treatments when using SDM during clinical practice.(9)

Around 90-98% of patients desire to be actively involved during a clinical encounter with their physician.(1, 4, 11) However, about one in three physicians report to perform paternalistic decision making, and around 60 to 67% of clinicians involve their patients in decisions about their care, but often do not see how SDM differs from their usual practice.(1, 12-16) Less than 10% of decisions meet the minimum standards for informed decision making.(17) Fifty-seven percent of general practitioners (GPs) did not offer multiple diagnostic or treatment options were possible, which is a requirement for SDM.(18) In addition, when patients were offered a choice, 70% of physicians admitted they made a preselection of options to discuss with their patient. Patients who would have preferred to make a different choice felt in most cases that they were not sufficiently involved in making this choice.(18) Most healthcare providers did not demonstrate that they were attempting to involve their patients with consistency. They expressed insufficient patient-involving behaviour.(10)

Applying SDM is not an easy task. The implementation can be limited due to factors related to clinicians, patients and the healthcare system.(19) Successful implementation of SDM into routine care will ideally require interventions targeting both the clinician and the patient.(19-21) It is of primary importance that the physician knows when and how to apply SDM.(22) Furthermore, clinicians suffer from common barriers such as time constraints, lack of knowledge and unfamiliarity with SDM.(22) Widespread adoption of SDM is challenging, unless clinicians fully understand the principles and benefits of SDM, and are well trained in engaging patients in their care.(19-22) There is little evidence on the effectiveness of current studies regarding interventions to increase the use of SDM. These interventions include training but also the use of decision aids. The lack of evidence is due to a very large variety of different interventions as well as large variation in outcome measurement.(19)

Knowles' adult learning theory suggests that learning improves when it is based on learner's specific needs and new concepts that have immediate relevance and impact to their job. Knowles was one of the first investigators to deal with the concept of educational need, which he defined as 'what a person should learn for the benefit of himself, an organization or society based on their own needs and experiences.'(23) Recent studies have shed light on educational demands regarding SDM and possible training methods.(24-26) Despite the existence of many training courses to learn to utilize SDM, training methods may not answer the educational need of our population, therefore increasing the chance that the training will not lead to the intended outcomes. Furthermore, many articles on the teaching of SDM to medical students and to graduated GPs don't go into depth about what the doctors' specific needs are to facilitate implementing the process in the daily practice and should be further investigated. Therefore, we aim to explore the educational needs of GPs and GP trainees (GPts) regarding teaching in SDM to contribute to the development of more evidence-based training programs for physicians in the future.

2. Materials and Methods

2.1. Study design

This project is part of a larger doctoral study at the Catholic University of Leuven on the implementation of SDM among physicians, including specialists, residents, GPs and GPts. This study will be a sub analysis and solely focus on the educational needs of GPs and GPts, excluding specialists and residents.

We conducted a qualitative study using semi-structured focus group interviews conducted with GPs and GPts. We chose a focus group design to create interaction between participants as it has the potential to provide in-depth information in a relatively short period of time.(27) The results of this study will support the development of an SDM communication training program, both for undergraduate medical students as for postgraduate physicians.

2.2. Ethical approval

Ethical approval was obtained by the Social and Societal Ethics Committee of the KU Leuven (file nr. G-2022-5511-R2(MAR)). Participants have given written informed consent upon participation.

2.3. Study population

2.3.1. Setting

In Belgium, a basic medical degree can be achieved by completing three years of undergraduate medicine, followed by three years of master's degree in medicine. During the Master of medicine, students have one year of mandatory internships during which they can make acquaintance with the working field of each medical discipline. During the last year of medical school or after graduation, students can apply for a discipline of their choice.

2.3.2. Participants

We conducted this study in Belgium involving GPs as well as GPs in training after graduating medical school, both working with patients in their daily practice. All participants have graduated medical school at one of the four Flemish universities (VUBrussel, KULeuven, UAntwerpen, UGent) and are Dutch-speaking.

2.4. Recruitment process

We contacted GPs and GPts from our local area by e-mail or by phone messages between September 2022 and March 2023. The researchers of this study are GPts and GPs themselves and recruited colleagues from their working area as well as old acquaintances from medical school. An information letter was sent in advance by e-mail to those interested in participating to the study. This letter described the background and aim of our study, the methods used and the confidential processing of personal data. Participants knew we were studying educational needs regarding SDM. They signed an informed consent before the start of the focus groups. None of the participants of the recruitment chose to drop out along the road.

2.5. Data collection

We conducted online semi-structured focus group sessions with 5-8 participants each, lasting around one hour using Microsoft Teams. Each focus group interview was moderated by one out of two moderators (BP, PVB) and two out of four observers (LVM, NR, JJ, PVB) were present, making notes. The moderators and observers are male and female GPs and GPts themselves, having studied at Flemish universities and currently working with patients in Flanders. At the start of each focus group, informed consent was once again addressed. Demographic data (age, gender, discipline, type of practice, experience, location) was obtained during an introduction round at the start of the focus group. The moderator guided the discussion using a predefined guidebook and participants were stimulated to join and speak freely. The interviews were initiated with several exploratory open-ended questions, inquiring about physician's initial perceptions about SDM and previous education regarding SDM. In half of the focus groups, a short presentation was held afterwards by the researchers, explaining the definition and importance of SDM. Then the interview continued and the moderator dove into more specific follow-up questions relating to possible new trainings, specifics, barriers and motivators in order to discover their educational needs. Focus groups were repeated until there was recurrence of comparable information and no new themes came up. After each session, the moderator and the observers debriefed and gave feedback on the focus group.

2.6. Data extraction

Video- and audio recordings were made for analysis during the focus groups. All recorded focus group sessions were transcribed verbatim during which the data was pseudonymized. The recordings were afterwards removed. After finishing the study, keys to the pseudonymization were destroyed as well as ensuring the data is anonymized.

2.7. Qualitative analysis

Data analysis was guided by the 'Qualitative Analysis Guide of Leuven' (QUAGOL).(28) This analysis consists of 10 steps which can be found in figure 1. QUAGOL provides an exhaustive and systemic

approach to the analysis of complex qualitative data. This synergetic, thorough approach minimalizes the degree to which individual viewpoints or backgrounds can dominate the interpretation.

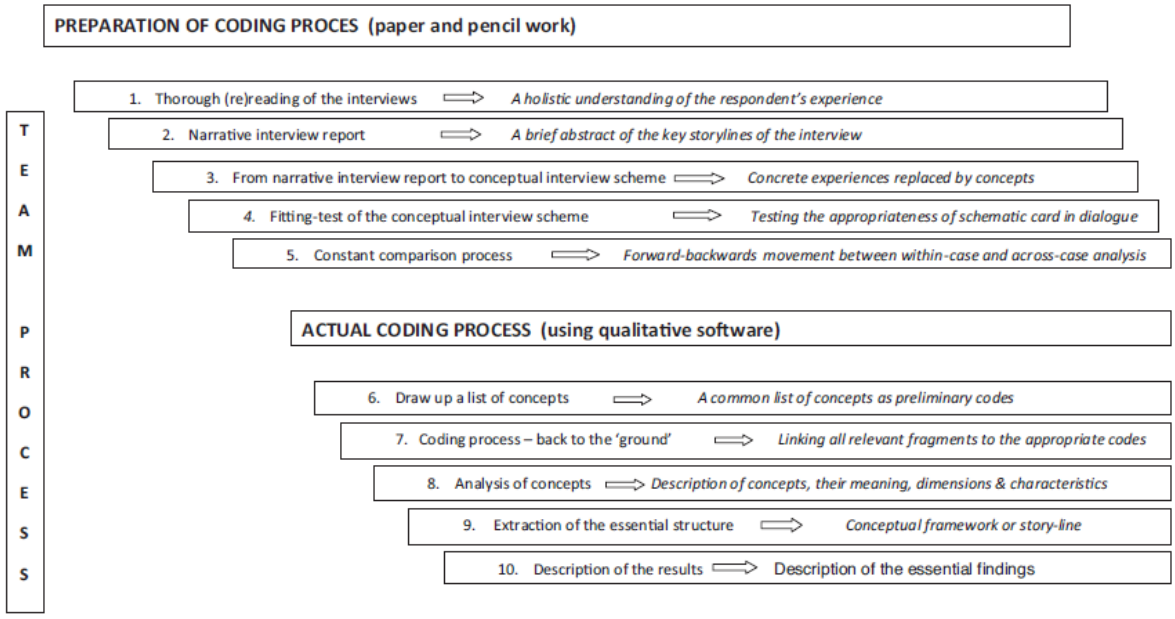


Figure 1: The 10 steps of the QUAGOL approach

Two investigators (NR & LVM) coded and analysed the transcripts in accordance with the methodology outlined in the Qualitative Analysis Guide of Leuven (QUAGOL).(28) Narrative and conceptual interview schemes were made. The codes were grouped in a scheme, analysed and extracted. We used ATLAS.ti as computer-assisted qualitative data analysis software. Each researcher coded each transcript and formed a coding tree which applied to the four transcripts, resulting in two separate coding trees. The two acquired coding trees were compared and discussed between the two researchers to form one overarching coding tree. Lastly, the interviews were coded using this new coding tree.

3. Results

3.1. Demographic characteristics

Four focus groups were conducted, consisting of a total of 25 participants. Two focus groups featured only graduated GPs, while the other two consisted of GPts only. Demographic details are outlined in Table 1. The group of physicians showed a sex-diverse composition encompassing 32% man and 68% woman. Geographically, the participants were distributed across both urban as well as rural settings in various provinces of Flanders, providing a holistic representation of diverse practice environments. The participants exhibited a diverse range of professional experience, contributing to a well-balanced representation of varied workplace tenures.

Table 1

Demographic characteristics of participants, consisting of GPs and GP trainees

Demographic Table	N
Participants	25
Graduated GPs	12
0 – 10 Years of experience	7
11 – 20 Years of experience	2
21 – 30 Years of experience	3
GP trainees	13
1st year	1
2nd year	6
Working in the hospital	3
3rd year	6
Current workplace	
Group practice	18
Duo practice	4
Solo doctor with GP trainee	3
GP trainee currently working in the hospital	3
Gender/sex	
Woman	17
Man	8
Geographical location	
Belgium, Flanders	25
Province of West Flanders	0
Province of East Flanders	2
Province of Antwerp	14
Province of Flemish Brabant	3
Province of Limburg	6
Setting	
Urban	14
Rural	11

Abbreviation: GP = General practitioner

3.2. Results of the focus group interviews

Our data analysis identified four educational needs concerning SDM: (1) Definition of SDM and its importance, (2) Implementation of SDM in daily practice and its use, (3) Teaching SDM generally, thoroughly, repeatedly and reflectively, (4) Time constraints of physicians and ways to bypass this. These themes can be further subdivided in themes describing the views of GP and GPts on SDM and its educational needs. In the following sections, each theme is thoroughly discussed and substantiated with quotes mentioned during the focus group interviews. (Table 2)

Table 2

Quotations from the performed focus group interviews suggesting underlying educational needs regarding SDM among GPs and GPts.

Q	FG	GP(t)	Educational need	Quote
Q1	FG3	GP1	Need for a clear definition of SDM	“SDM is about informing the patient very well first, so that the patient can still make a decision on their own or a well-informed one that they can support."
Q2	FG1	GPt4	Need for insight into added value of SDM	“The benefits of SDM must be tangible … certain studies or RCT significant results can show why SDM may be an ideal option within a given setting.”
Q3	FG1	GPt2	Need for know-how on implementation of SDM	“As a starting GP trainee, I noticed that implementing SDM was sometimes still difficult because you're still struggling a bit with what am I going to give as a decision or treatment and where to involve the patient … so I think if, before you even start working, more applicable tools or some more practice in SDM, that could have been useful.”
Q4	FG4	GP3	Need for SDM to battle specific challenging situations	“When someone comes asking about benzodiazepines and you don't actually want to prescribe it, then how do you go about it.”
Q5	FG3	GP4	Need for SDM to battle specific challenging situations	“Other barriers are also situations where communication is difficult. Whether it's language or sometimes it's also, thinking of people with mental disabilities or so on, then you're also often going to say: I'm going to choose for this person what I think is going to fit best.”
Q6	FG2	GPt5	Need for SDM to battle specific challenging situations	“My geriatric patients often say, “yes doctor what you say will be right.” Although in terms of their pathology maybe SDM would be the best approach for them.”
Q7	FG2	GPt1	All physicians need to learn SDM	“I think there is definitely an indication to give SDM a little earlier in training, or simply to the other specializations … Because I notice that GPts are pretty good at shared decision making, but if you compare that with other specializations, it's much less discussed.”
Q8	FG4	GP2	Need for implementation in the longitudinal curriculum	“I thought it was definitely present in the basic training at the time, but I didn't really see the point of it at the time, whereas in the GPt training I thought it became more obvious because you work with real patients in practice, I thought that was a big difference actually.”

Q9	FG2	GPt2	Need for in-depth learning	"I remember SDM has come back in every course from time to time, but never in depth. (…) The gap, for me, lies in the training and actual practice."
Q10	FG2	GPt2	Need for repetitive learning	"I think it has a place in all subjects and it's important everywhere but the gap for me is definitely training, practising and indeed basing communication training on the topic of SDM."
Q11	FG4	GP5	Need for reflective learning	"I think that those video recordings, however unpleasant they may be, would work to identify areas for improvement and to see where you can make progress."
Q12	FG3	GP2	Need for a fit within physicians' busy schedules	"If we are honest, I think we are all just going to pay less attention to SDM sometimes too out of lack of time."
Q13	FG3	GP5	Need for usable and findable tools to facilitate SDM	"If I know where to find those tools, yes, and then to use them once, then I would be satisfied. And then you get a bit used to all those tools, because that's often it, if you've already used it once then it's much easier to use it again next time."

Abbreviation: FG = Focus Group, GP = General Practitioner, GPt = GP trainee, SDM = Shared Decision Making

3.2.1. Definition of SDM and its importance

3.2.1.1. Need for a clear definition of SDM

Whilst most physicians had heard of SDM, we noticed that their understanding of SDM often does not align with the correct definition. When participants were asked about the definition of SDM, most participants said that for them, SDM was about searching together with the patient as opposed to clinicians making decisions on behalf of patients. They often added that the doctor should inform the patient sufficiently and that patients should decide themselves, pointing towards informed decision making (Q1). Informed decision making involves making choices by the patient, only based on comprehensive understanding and consideration of relevant information, lacking multiple aspects of SDM. Many times during the interviews, SDM was perceived by the participants as the patient deciding on their own, even if it completely opposes the opinion of the physician. This disparity between perceived and actual definition may have implications towards motivation of SDM implementation, as physicians fear to lose their own involvement in the decision-making process. This educational need was not explicitly voiced by the participants but inferred by the researchers.

3.2.1.2. Need for insight into added value of SDM

Participants believed that being educated on the evidence of SDM on patient care, outcomes and compliance could heighten the desire to incorporate SDM into their daily clinical practice. Notably, a participant cited the belief that SDM is unimportant as a barrier to its implementation (Q2). The perceived lack of clear tangible benefits of SDM may hamper its use by physicians.

3.2.2. Implementation of SDM in daily practice and its use

3.2.2.1. Need for know-how on implementation of SDM

Knowing what SDM is about is one thing, but knowing when and how to use it, is something else. Participants admitted to having a lack of know-how on the implementation of SDM and point to the lack of education on the topic. They miss tools, an easy model to use and fall back on. Especially for starting GP trainees, who are still struggling with many other aspects of consultations, applying SDM is a hard task (Q3). The need to learn the process of implementation of SDM in daily practice, prior to engaging the working field, was also mentioned (Q3). Here we observe two different underlying educational needs: which medical tools can be used for applying SDM and where can these be found as well as which SDM models and example questions can be used to implement SDM and where can these be found.

3.2.2.2. Need for SDM to battle specific challenging situations

Some participants find SDM important during all clinical encounters, while others state SDM is only important in certain situations, limiting its use. This implies that there is an educational need on anticipating in which situation SDM may or may not be appropriate. Many participants could identify situations were SDM would be very challenging and would prefer guidance in how to handle these situations. SDM was identified as especially valuable when addressing challenging topics such as benzodiazepines (Q4), navigation fake news, managing individual complex cases such as in patients with poor communication skills and cultural differences. Communication between healthcare professionals and patients is influenced by many factors. Participants state that a language barrier or poor communication skills in general prove to be a stumbling block to apply SDM. Poor language skills complicate the transmission of accurate medical information, and takes already a lot of skills, so that applying SDM on top of it, feels difficult. Poor communication may also lead to incorrect understanding by patients. As a result, improper medical advice can negatively influence the decision-making progress. In this situation, it seems more convenient to use patriarchal decision tactics (Q5). With the evolving patient population and medical knowledge, participants see a trend where patients want to be more engaged. In contrary, especially elderly patients still have a preference towards a paternalistic approach, complicating the choice to implement SDM in daily practice (Q6).

3.2.3. Teaching SDM generally, thoroughly, repeatedly and reflectively

3.2.3.1. All physicians need to learn SDM

Physicians recognize the utility of SDM in the primary care setting. However, they emphasize the importance of all physicians acquiring SDM skills and extending it to specialists. The participants believe implementation of SDM is even lower by specialists as it is less discussed during their education. This could also ensure a better cooperation between primary and secondary care. One participant proposes acquiring these skills early in the education as this could ensure this widespread adaptation (Q7).

3.2.3.2. Need for implementation in the longitudinal curriculum

Some participants mentioned they want SDM education early enough, but others admitted that too early is not ideal, as medicine students lack clinical experience. Training at early stages may feel irrelevant. As a result, participants may insufficiently recall information acquired during the training (Q8). SDM should be taught early enough to get the basics of it. Further on during the curriculum, and as a medical graduate, more and more in-depth the communication skills should be taught.

3.2.3.3. Need for in-depth learning

Physicians have admitted they are familiar with the concept of SDM, as all of them acknowledge its existence. Even though, participants demonstrated familiarity with SDM, they had limited recollection of education during medical school. Despite noticing high variations in communication training across universities, as well as across generations, specific communication training on SDM was clearly lacking everywhere. Some of the participants recall it was added as a part of theoretic classes and being the first topic to be skipped or paid less attention to by both students as well as educators. Classes didn't go in depth regarding this topic. One participant highlighted that SDM is important and implied it should be more extensively discussed (Q9).

3.2.3.4. Need for repetitive learning

A clear educational need was mentioned of wanting to be trained in SDM and wanting to practice repeatedly via multiple training opportunities to progressively improve their SDM skills. Participants expressed the need for practical trainings to really get the hang of it (Q10).

3.2.3.5. Need for reflective learning

In Flanders, GPts must record some of their private consultations during their GP training for learning purposes. Therefore, the idea of recording a consultation of your own for reflective learning was discussed. Most of the participants declared to believe that recording themselves helps finding areas of improvement but they also indicate the process of recording might be disturbing (Q11).

3.2.3.6. Desired training formats

When we asked participants about desired training formats regarding SDM, several formats to incorporate SDM-training were discussed. The formats that were most widely discussed, were e-learnings and live learning. E-learnings seemed to be more accessible for most participants, while live learning was thought to be more interactive and therefore more efficient for learning how to utilize SDM. Physicians also provided several suggestions on what a refreshing course in their opinion should look like: there should be a concise summary, take home messages, interesting clinical themes.

3.2.4. Time constraints of physicians and ways to bypass this

3.2.4.1. Need for a fit within physicians' busy schedules

During the focus group interviews, the busy time schedule of physicians and its effect on the implementation of SDM were mentioned. Educational needs regarding time seem to focus on possibilities and tools to keep SDM within the foreseen time of a consultation. Physicians hold the feeling that applying SDM is time-consuming which restrains GPs from utilizing SDM in their daily practice (Q12). The barrier of time has some confounders which were also discussed. Among these, especially shortages of GPs, increasing workload and performance-drifted medicine were mentioned.

3.2.4.2. Need for usable and findable tools to facilitate SDM

Tangible tools which may facilitate the use of SDM were discussed. Educational brochures for patients were mentioned, as well as index cards for doctors or ready-made themed decision aids for certain pathologies to run through together. Although participants acknowledge the existence of tools to implement SDM, they admit it is hard to find and use them (Q13). The participants did not differentiate between decision-aids specific to certain medical pathologies or communication tools that generally help SDM implementation. One participant suggested the creation of a main website where tools and decision aids can be found.

4. Discussion and conclusion

4.1. Discussion

In this study, we explored the educational needs of GPs and GPts regarding SDM in medical school and postgraduate medical education in order to gain in-depth information on how to enhance education on the topic of SDM. We identified four major themes which could be subdivided in several educational needs: (1) Definition of SDM and its importance, (2) Implementation of SDM in daily practice and its use, (3) Teaching SDM generally, thoroughly, repeatedly and reflectively, (4) Time constraints of physicians and ways to bypass this.

4.1.1. Reflection on main findings

One of the main educational needs we discovered, was acquiring the correct definition of SDM and its scope. During the focus groups, we noticed that participants had different ideas on what SDM is about. This feeling was further enhanced when participants were showed an introduction PowerPoint that highlighted the features of SDM, since their ideas regarding SDM did not fit those shown in the PowerPoint. Another study in professionals of fertility care and intensive care also noticed that not everyone is familiar with the correct definition of SDM.(24) In the interviews with professionals, many initially interpreted 'shared' as 'decisions made by a team of professionals'.(24) Lack of clarity on the correct definition may be explained by poor training on the topic of SDM. Participants cited that they no longer have many recollections of SDM from medical school and when they do, it was only very briefly mentioned during a course. More in-depth theoretical learning may facilitate the teaching of the concept of SDM and may affect the training and sustainability of SDM in the future. Other research also found this educational need of more knowledge.(26) Some participants believed that SDM is an innate skill which may lead to complacency regarding the need for further education. It hinders the recognition of gaps in understanding. An analysis of the MAGIC program (a program involving a structured approach to facilitate shared decision making in healthcare) cited that the thought that physicians already engage in SDM in their existing practice hinders the implementation of SDM.(29) Understanding the correct definition of SDM is of prime importance to correctly implement SDM in daily practice. Consequently, we discovered an educational need in learning how to correctly apply SDM. Our study shows that for participants it is necessary to start the learning process of what SDM entails, early enough to prevent bad habits from being implemented. To overcome this barrier, a training on SDM could be organised that identifies and adresses GPs individual deficiencies within their SDM practice to recognise areas of improvement.(26)

To engage in learning SDM, awareness and motivation seems to be essential.(3, 30) Supporting clinicians' understanding of the rationale behind SDM can enhance their attitude and receptiveness to SDM training, thus facilitating its implementation in regular practice.(3) Our study showed a demand for statistical evidence of SDM on patient care, outcomes and compliance. Participants mentioned that the lack of evidence-based information limits its implementation. Communicating research evidence during didactic teaching has also been previously suggested.(25) This finding underscores this critical importance of integrating evidence-based research on SDM into educational initiatives. Besides that, there are several other factors that influence implementation of SDM. During the focus groups, participants mentioned that SDM was the way to go to tackle specific clinical topics such as sedatives, complex individual cases and handling fake news. This implies that SDM-training based on specific clinical situations may have an added value for physicians. This is in line with a similar study in GP residents, where the investigators demonstrated SDM to be especially relevant to specific decisions. The participants of this study elaborated that SDM is especially valuable in complex decision-making processes that have important consequences for patients. However, they cited decisions in primary care about lifestyle, psychosomatic complaints, chronic diseases and end-of-life care, which differ from

the specific themes mentioned in our study.(26) One study in GPts confirms our finding that GPts feel lacking knowledge of therapeutic and diagnostic options, as well as the lack of acquired communication skills, hinders the implementation of SDM. The investigators of this study also confirm our results that perceived barriers such as language barriers and health literacy impact the motivation to implement SDM.(26)

GPs and GPts mentioned the importance that all physicians, including specialists and residents, learn about SDM and how to implement it. They think this could also ensure a better cooperation between primary and secondary care. This finding suggests that SDM-training should be applicable for every medical specialization and that interdisciplinary courses on SDM might be useful. Participants have stated that gaining proficiency in SDM necessitates a sustained, longitudinal learning journey. This confirms research emphasizing the importance of consistent focus and repeated learning opportunities throughout postgraduate medical education as well as combining didactical teaching with active practice.(4, 25, 31, 32). The need for reflective learning, by themselves as well as peers, and constructive feedback, that has been shown in our study, was confirmed in other studies.(24, 25, 26) Furthermore, our participants expressed the desire for live as well as e-learnings and hoped for refreshing trainings on specific themes and clear take home messages. Other research demonstrated that GP's stated role-play, receiving feedback and on-the-job learning as ways of SDM training that positively changed their SDM in clinical practice the most.(25) As research shows most interventions are limited in their effectiveness, we summarize this theme by proposing a combination of different and repeated trainings, at different times of a physician's education and career.(5, 20, 26, 33)

Lastly, barriers that hamper the implementation of SDM were mentioned. The perceived barrier of time constraint seems to have a big impact on the use of SDM by physicians and demonstrates the need for tools or education to bypass this. A recent study showed that applying SDM does not necessarily require longer consultation time. If SDM is taught in an approach that is theory-based and also focuses on multilevel implementation, it could lower the risk of increasing consultation time.(32) Our participants claimed that having tools that are easily and quickly accessible in order to apply SDM might also positively influence implementation of SDM and decrease the perception of time constraint. Further research should assess this hypotheses.

4.1.2. Strengths and limitations

We conducted four focus groups for which we individually invited GP(t)s from our personal working field. GP(t)s had the choice to voluntarily take part in the study. This implicates that, possibly only motivated GP(t)s with an interest in SDM took part. Because of the high workload of GP(t)s, it was very difficult to find a date to host a focus group, which explains our low sample size.

Regarding demographics, the participants of this study were very diverse.(Table 1) The distribution in rural and urban working field was nearly equal and the number of GPs and GPts as well. Additionally, the working fields of the participants were scattered across Flanders, except West Flanders. This gives a more broadly insight on how physicians all over Flanders think about being educated in SDM .

The focus groups themselves were held online, which may influence the interaction. In two of the four focus groups, there was an introduction with a PowerPoint, while in the other two focus groups there was not. This may alter the insight of the participants.

After conduction of the focus groups, all recorded focus group sessions were transcribed verbatim during which the data was pseudonymized. Afterwards, the data was analyzed individually by two researchers (LVM, NR). After individual analyzation and formation of a coding tree, the coding trees were compared, and a general coding tree was formed. With this coding tree, the data was analyzed

for a second time after which the coding process was fulfilled. The data was reported according to the COREQ checklist.(34)

4.2. Conclusion

GP and GPts expressed the need for continuous attention for SDM during medical school and during postgraduate medical education. They mentioned the need for all medical students to gain more theoretical insight early on, which could further enhance the process of SDM training. This would allow physicians to get more experienced with SDM during their education which would help them to battle specific clinical themes. Applicable, tangible tools to facilitate the implementation of SDM should be further optimized and should be made easily accessible for both physicians and patients. With experience in SDM and accessible tools for SDM implementation, physicians could be equipped to address barriers such as time constraints and navigate specific challenging situations more effectively.

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