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RESEARCH ARTICLE



Shared decision making in pelvic organ prolapse: a thematic analysis of healthcare professional perspectives

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ABSTRACT

Shared decision-making (SDM) is widely recognized for its benefits in patient-centered care, yet its application in the treatment of pelvic organ prolapse (POP) presents notable challenges. This study explores healthcare professionals (HCPs) experiences with SDM, identifying barriers and facilitators to its implementation. Twelve HCPs involved in POP management were interviewed. The data was analyzed using reflexive thematic analysis, revealing four key themes: (1) Experiences with SDM, (2) Differences in HCP perspectives, (3) Patient characteristics, and (4) Information provision. While HCPs value SDM, they face challenges including limited patient health literacy, time constraints, and differing patient expectations. Key facilitators included clear, tailored communication, structured patient education, and effective multidisciplinary collaboration. This study emphasizes the importance of preparing patients for active participation in SDM by enhancing health literacy and improving communication. Overcoming barriers and using facilitators can enhance SDM quality in clinical practice, improving patient outcomes and satisfaction in POP care.

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barriers and facilitators

Introduction

Pelvic organ prolapse (POP) significantly affects the quality of life of many women worldwide. With an aging population, ~50% of women are expected to experience POP [1,2]. POP is characterized by the descent of pelvic organs, such as the bladder, uterus, and bowel, often resulting in symptoms like vaginal bulging and urinary issues [3]. The severity of these symptoms is crucial in determining the most appropriate treatment. As healthcare resources become more limited, efficient treatment decisions are essential for ensuring high-quality care and optimizing outcomes.

Treatment options for POP range from conservative management, such as pelvic floor therapy to surgery; with no treatment proven to be clinically superior [4]. This highlights the need for SDM between patients and HCPs. POP is a chronic condition requiring ongoing management, making SDM a continuing process

rather than a one-time treatment decision. SDM facilitates the customization of treatment based on each patient's unique needs and preferences. By integrating medical expertise with patients' preferences, SDM can improve treatment satisfaction and adherence [5].

Despite national efforts to promote SDM, patient experiences have not improved since 2016 [6]. Research highlights discrepancies in the perceptions of SDM between healthcare professionals and patients, hindering its practical implementation [7]. While previous studies have explored the perceptions of SDM between nurses and physicians in other contexts, there is limited research on HCPs' experiences with SDM in POP treatment [7,8]. This study aims to fill this gap by examining HCPs' experiences with SDM in the management of POP, identifying barriers, facilitators, and recommendations for its improved implementation.

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Methods

This study used semi-structured interviews to explore the experiences of healthcare professionals with SDM in the management of POP. The study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [9].

Study design

An interpretative design was used to examine HCPs decision-making processes [10]. Interviews were conducted by JV, a female health sciences student with a nursing background, completing a research internship. The researcher had no prior affiliation with the participants' workplaces. A semi-structured interview guide was developed and further refined after a pilot interview [10].

Study population

HCPs actively involved in POP management, including gynecologists, physician assistants, physiotherapists, and a general practitioner. Recruitment was achieved through convenience and snowball sampling within the research supervisors' networks (Table 1). Participants had at least six months of professional experience in POP management. Interviews were conducted in person or online, based on participants' preferences.

The interviews followed a semi-structured guide designed to explore HCPs' views on decision-making in POP treatment. Three cases were presented to participants to guide the discussion on their treatment approaches. Interviews were audio-recorded, transcribed verbatim in Dutch, and included open-ended questions to encourage in-depth responses [10]. Data saturation was reached after nine interviews, with three additional interviews confirming saturation, resulting in a final sample size of 12 participants.

To ensure accuracy, transcripts were shared with participants for review. An audit trail documented the research process, while self-reflection minimized bias. The interview guide was based on the Self-Determination Theory and the Difficulty x Motivation Matrix to examine how individual preferences and decision complexity influence decision-making in SDM [11,12].

Data analysis

Interviews were transcribed and analyzed using ATLAS.ti software (version 24.1.0) to identify patterns and themes [13]. An inductive coding approach was used, with codes grouped into broader themes. Reflexive

analysis was prioritized through iterative meetings with the research team, leading to the development and refinement of themes [14,15].

Ethical considerations

Participants provided written informed consent for interviewing, and confidentiality was ensured through anonymization. Participants could review transcripts for accuracy. The study did not fall under the Medical Research Involving Human Subjects Act, and ethical approval was obtained from the institutional review board (IRB).

Results

Twelve healthcare professionals (HCPs) from different disciplines involved in managing pelvic organ prolapse (POP) participated in the study. Of the fifteen invited, two did not respond, and one was excluded due to a late reply. Interviews were conducted in person (three) or *via* Microsoft Teams/phone (nine), lasting between 25 and 55 min (average: 35 min). Data saturation was reached after nine interviews. Inductive reflexive thematic analysis identified four main themes: (1) Experiences with shared decision-making (SDM), (2) Differences in HCP perspectives, (3) Patient characteristics, and (4) Information provision (Table 2).

Experiences with SDM

All HCPs recognized the importance of SDM in improving patient outcomes and satisfaction. They emphasized the need to incorporate patient preferences into treatment decisions. However, challenges were reported, including time constraints, varying health literacy, and language barriers, which often required additional support. Approaches to SDM differed across disciplines, and external factors, like guidelines, also affected the process. A multidisciplinary approach was seen as valuable, but inconsistencies in care and information across institutions were noted as barriers.

Differences in HCP perspectives

Generational differences influenced how HCPs approached SDM. Older doctors tended to take a more directive role, while younger doctors, trained with a stronger focus on SDM, engaged more collaboratively with patients. Non-doctor professionals, such as physiotherapists and nurse practitioners, emphasized the importance of clear communication and teamwork. They play a key role in the SDM by providing

Table 1. Healthcare professionals characteristics.

Healthcare professionals characteristics		Frequency (N)
Age	20–29 yrs	1
	30–39 yrs	2
	40–49 yrs	4
	>50 yrs	5
Gender	Male	3
	Female	9
Profession	Gynecologists	7
	Gynaecological resident	1
	General practitioner resident	1
	Physician assistant	1
Years of practice	Pelvic Physiotherapist	2
	0–5 yrs	6
	6–10 yrs	1
	11–20 yrs	2
	21–30yrs	0
Practice location	>30 yrs	3
	General Hospital	8
	General practitioner practice	1
	Pelvic floor specialized physiotherapy care	3

additional support and perspectives alongside medical advice.

Patient characteristics

Health literacy, cultural background, and education level influenced how patients engaged in SDM. Educated patients often arrived well-prepared, while those with lower education levels needed more detailed explanations. Misconceptions about treatment, like believing surgery would resolve all symptoms, sometimes prevented the consideration of alternative treatments like pelvic floor therapy. Health literacy and language barriers further complicated SDM, with patients often misunderstanding basic information. HCPs suggested decision aids and proactive patient involvement could help improve understanding and engagement.

Information provision

Clear and tailored communication was essential for SDM. HCPs used techniques like the teach-back method and visual aids, although responses varied. The quality and consistency of information provision differed across institutions. Some offered comprehensive resources like brochures and decision aids, while others lacked standardization. Educational videos were being used to improve understanding, although patient reactions to these materials were mixed. HCPs emphasized the importance of providing relevant information without overwhelming patients. Preparing patients in advance was found to focus discussions and enhance engagement.

Table 2. Quotes of participants.

Theme	Quote
Experiences with SDM	"You do nothing but SDM; it is the cornerstone of the degree nowadays." – HCP 5
	"Time and an overload of information (.) no, that is too much. (.) Barriers include patient characteristics, like language and health literacy." – HCP 10
	"I strongly advocate for conducting this in a Multidisciplinary Team Meeting. It allows for a holistic approach to patient management." – HCP 8
Differences in HCP perspectives	"Older doctors, near retirement, still hold the view that the doctor should make the decision." – HCP 1
	"Before a doctor decides to send a patient to a pelvic floor physiotherapist, I think they should consult to assess if this is an indication." – HCP 11
	"The older I get, the more I tend to speak more frankly and guide patients towards this option." – HCP 2
Patient characteristics	"The younger and higher educated patients often come prepared with their own research. I adjust my communication accordingly." – HCP 6
	"Sometimes patients have such clear ideas that they won't engage in a discussion." – HCP 9
	"Sometimes they understand less than we think they do. Occasionally, they ask a question and I think, 'Oh dear, this didn't come across well'" – HCP 5
Information provision	"The information is a lot; I always hope that they have someone with them who also absorbs the information. I show pictures, but it remains a tricky thing." – HCP 5
	"I would want a decision aid that is suitable for all patients, particularly with increasing demand and waiting lists." – HCP 2
	"Prior to the consultation, providing information in advance allows the discussion to focus on specific patient needs." – HCP 10

Discussion

This study highlights both facilitators and barriers to SDM in POP management. While HCPs recognized the value of SDM, challenges such as time constraints, health literacy issues, patient-related factors and misconceptions hinder its practical application [16,17]. These barriers reflect both patient and HCPs challenges in addressing knowledge gaps. Improving SDM requires both patient education and targeted HCP training in communication strategies [18,19].

A key dynamic in SDM is the epistemic gap between patients' personal knowledge and HCPs' medical expertise [20]. This misalignment can hinder decision-making, particularly when patients expect surgery as a quick fix, while HCPs understand its risks [16]. Bridging this gap requires improved communication strategies, including the use of decision aids, empathetic listening, and the teach-back method [21]. Decision aids can help patients understand their options, while HCPs must engage with patient narratives to align on goals and expectations [17,22].

Collaboration at multiple levels is essential for effective SDM. HCPs need training in communication and tailoring information for diverse patient populations. Research by Barton et al. [18] and Driever [19] shows that comprehensive SDM training improves both patient outcomes and clinical workflows. Additionally, preparing patients before they meet HCPs ensures they have a basic understanding of their condition and treatment options [23,24].

Patient organizations are key stakeholders in bridging the gap between patients and HCPs, by providing objective information, supporting peer-to-peer communication, and advocating for patient-centered care. They also empower patients to participate in SDM by offering resources grounded in both professional expertise and lived experiences [25]. Strengthening partnerships between HCPs and patient organizations can promote a more inclusive SDM process [26].

The overburdened healthcare system challenges SDM, with time constraints often leading to incomplete discussions and more directive approaches [27]. Shifting conservative treatments like pelvic floor therapy to primary care would reduce secondary care workload and allow specialists to focus on complex cases [28].

While much research on SDM focuses on patient involvement, this study emphasized HCPs perspectives. The diversity of professionals involved in POP treatment strengthened the findings, but the use of convenience and snowball sampling may have introduced bias. Moreover, the dominance of medical doctors' views, without patient input, limits the ability to fully capture the SDM experience. Future studies should address this gap.

Future research should explore better prioritization of clear communication strategies, the use of decision aids, and the integration of multidisciplinary collaboration in SDM. Training HCPs in communications skills, cultural competence, and tools like the teach-back method is also crucial. Finally, investigating how healthcare systems can shift tasks like pelvic floor therapy to primary care would help improve efficiency and patient care.

Conclusion

HCPs recognize the importance of SDM in POP treatment, but practical challenges such as time constraints and varying health literacy levels complicate its implementation. While a patient-centered approach is ideal, some patients require more directive guidance. Enhancing SDM requires both HCP training and better patient preparation to align expectations and improve decision-making.

To optimize care despite increasing healthcare pressures, efficient SDM strategies—such as decision aids, multidisciplinary collaboration, and shifting non-specialist treatments like pelvic floor therapy to primary care—are essential. These steps will help ensure that patients receive the right care at the right time and place, improving both patient outcomes and healthcare system efficiency.

While healthcare resources are becoming more and more limited, efficient SDM and care provision with the right care at the right time and place is crucial.

Disclosure statement

The authors declare no relevant financial or non-financial conflicts of interest in relation to this study.

Author contributions

J.L.S. Vossen: Conceptualization, data curation, formal analysis, methodology, and writing – original draft. L.E. Drost: Conceptualization, formal analysis, methodology, and review & editing. L. ter Beek: Methodology and writing – review & editing. M.C. Vos: Conceptualization, formal analysis, methodology, supervision, and writing – review & editing.

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