

Original Research Article

Knowledge, attitude and practice of shared decision-making among Indian physiotherapists

Brinda Parthasarathi^{1*}, Saritha K. Francis², Sandeep P. H.¹, Kavitha Raja³

¹Department of Community Health, JSS College of Physiotherapy, Mysuru, Karnataka, India

²Department of Movement Science, JSS College of Physiotherapy, Mysuru, Karnataka, India

³Principal, JSS College of Physiotherapy, Mysuru, Karnataka, India

Received: 04 September 2025

Revised: 16 October 2025

Accepted: 17 October 2025

*Correspondence:

Dr. Brinda Parthasarathi,

E-mail: brindap1999@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Shared decision-making (SDM) is a collaborative approach in which physiotherapists and patients jointly make treatment decisions by integrating clinical evidence with patient preferences. Shared decision making has been associated with improved rehabilitation outcomes globally yet its uptake in low- and middle-income countries like India remains unclear. Hence, the objective of this study was to assess the knowledge, attitude, and practice of shared decision-making among Indian physiotherapists.

Methods: Study incorporated a cross-sectional survey among 109 physiotherapists across India using a validated questionnaire assessing knowledge, attitudes of shared decision-making implementation across various clinical conditions, and real-world shared decision-making practices. Data were collected and analysed using descriptive statistics.

Results: While 99% of participants correctly identified the purpose of shared decision making only 3.66% demonstrated full knowledge, revealing a significant deficit. While attitudes were most favourable in chronic and orthopedic care, half viewed shared decision making as confusing or time consuming. Although many discussed conditions and treatment options with patients, 66% did not communicate evidence-based benefits and risks highlighting lack of evidence practice in patient-centred care.

Conclusions: The study revealed limited comprehensive knowledge but a generally positive attitude and partial adoption of shared decision-making practices among Indian physiotherapists. These findings highlight a need for targeted education and training to enhance evidence-based shared decision-making in physiotherapy practice.

Keywords: Attitude, Evidence-based care, India, Knowledge, Physiotherapy, Practice, Shared decision-making

INTRODUCTION

Shared decision-making is a collaborative process that involves patients, physiotherapists, and clinicians making decisions regarding the patient's health after discussing the available options; identifying the merits and demerits of each option; and considering the patient's values, preferences, and personal circumstances.¹ It is also known as patient-centered decision-making or patient-centered shared decision-making. The growing evidence of the

need of patient centric approach has made it crucial to adapt shared decision making in physiotherapy and rehabilitation process.²

Shared decision-making involves an open discussion between the therapist and the patient.² The therapist provides evidence-based information about the options and balanced information about the merits, demerits, and uncertainties of each option including watchful waiting where appropriate, and uses their communication skills to

actively listen, engage, elicit patient preferences, advise the patient in accordance with their preferences and address their concerns and provide patient-centred care by encouraging patients to take an active role in the decision-making process and promotes ethical practice by respecting informed patient choices, ensuring fairness, and acting in the patient's best interest.^{3,4}

Studies conducted across the globe on various population such as community dwelling, palliative rehabilitation, chronic condition and musculoskeletal conditions have shown that incorporating shared decision making in clinical practice have shown to improve patient-clinician communication, improve patients' accuracy of their expectations of intervention benefits and harms, feeling of being informed and increase both patients' and clinicians' satisfaction with care providing better rehabilitative outcomes and improve in quality of life.⁵⁻¹¹

A top-down approach in healthcare involves policy-driven decisions from higher authorities, aiming for standardization and alignment with public health goals.¹² Shared decision making requires reciprocal communication and value-based negotiation, which may be limited in top-down models. Top-down strategies for promoting shared decision-making offer benefits like uniform expectations, resource allocation, and professional norm-setting. However, the approach has limitations without active grassroots level involvement and genuine clinician engagement, top-down initiatives may reflect institutional compliance rather than commitment.¹³

The lack of publications from low middle income countries like India is suggestive of the concern that shared decision making is still a relatively 'foreign concept' within physiotherapeutic consultations and management. Moreover, decision making in clinical cannot be enforced solely through policy; it demands a deeper shift in mindset, attitude change rooted in trust-building, reflective and continuous learning at every level of care. Thus, this study aimed to examine insights from grassroots level regarding shared decision making to understand the attitude and practice among physiotherapists in India regarding shared decision-making in clinical care.

METHODS

The study used an observational cross-sectional design using a survey method of physiotherapists in a metropolitan region of southern India. The study was done in a tertiary care hospital- JSS Hospital Physiotherapy department, Mysuru. from January 2025 to April 2025. The participants included were, with a minimum of a bachelor's degree which is the minimum required qualification to practice in India. Additional inclusion criteria consisted of the participants' ability to

use phone or social media platform and comprehend written English. Any individual who is a student physiotherapist residing in India were not included in the study

The study involved two phases. Following approval for research from Institutional review committee (reference number JSSCPT/IRC/OS-11/2025-26) the Nine item shared decision-making questionnaire (SDM-Q) was chosen to measure practice. A self-developed questionnaire using inputs from available literature was utilised for knowledge and attitude assessment.¹⁴⁻¹⁶

Knowledge was assessed using ten closed-ended true/false questions, with responses analysed by percentage. Attitudes toward shared decision making were measured through a five-point Likert scale across thirteen common physiotherapy conditions, evaluating agreement levels via mode and percentage. shared decision-making practice was examined using the nine-item SDM-Q questionnaire, where physiotherapists rated their agreement with statements reflecting decision-making behaviours during their most recent treatment consultation analysed using mode and percentage.¹⁴

In the phase two the two questionnaires were combined and using an online survey platform google forms. The survey was designed for dissemination among the target population. The list of registered physiotherapists as obtained from the local registration authority and a general email requesting participation was sent to all. The individuals who responded to the mail were approached individually via mail and a formal informed consent was obtained. Thereafter, the questionnaire was converted to a link and sent to the individuals who signed the informed consent. A period of four weeks was given to fill in the form, and a reminder message was sent weekly. Those who did not respond after the fourth week were not contacted again.

The responses obtained were collected and stored in a secure drive which was monitored by the IRC of the institution. The responses obtained were exported on Microsoft Excel spread sheet version 18.2503.12711.0 and used for data analysis. Data were analysed using descriptive statistics.

RESULTS

Understanding the demographic characteristics of the study participants is important for interpreting the findings. A total of 109 responses from individuals who provided consent for participants were analysed. The detailed demographic characteristics of the study participants are shown in Table 1.

Table 1: Demographic characteristics of the participants.

Demographic characteristics		Number of participants
Total number of participants	109	
Gender	Male	27
	Female	82
Age (in years)	20-25	71
	26-30	26
	31-35	8
	36-40	3
	41-50	1
Highest physiotherapy qualification	Bachelor's degree	67
	Master's degree	35
	PhD	5
	Other (e.g., postgraduate diploma or certificate courses)	2
Number of years of work experience	0-1 years	69
	1-5 years	32
	6-10 years	3
	11-15 years	5
Main area of practice	Chronic musculoskeletal conditions	21
	Acute musculoskeletal conditions	10
	Sports physiotherapy	13
	Neurological conditions	19
	Paediatrics	11
	Cardiopulmonary conditions	5
	Women's health (including obstetrics and gynecology)	2
	General (work across all areas)	16
	Ergonomics and occupational health	1
	Community health sciences	8
	Others	3

Table 2: Responses of participants to the questionnaire knowledge about shared decision making.

Questions	Responses obtained		
	Answer/responses	Frequency of the response	Percentage of correct responses
The purpose of shared decision-making is to help the patient become aware of the about available options	Correct response	108	99
	Incorrect response	01	
To promote shared decision-making, a physiotherapist informs many options including option of no treatment	Correct response	89	81.65
	Incorrect response	20	
Whenever possible, a physiotherapist should integrate the patient's preferences when deciding what to do next	Correct response	103	94.40
	Incorrect response	06	
By doing shared decision-making, patients may be more likely to adhere to the chosen treatment plan	Correct response	105	96.30
	Incorrect response	4	
If there are aids (like pamphlets or posters etc.) that help to summarize the benefits and harms of different treatments it would be helpful for patients in making a decision	Correct response	102	93.95
	Incorrect response	07	
Whenever possible, I should try to explain the natural history of a condition to patients and what might happen without active treatment	Correct response	103	94.40
	Incorrect response	06	
Shared decision-making may create confusion in patients regarding what treatment to choose	Correct response	68	62.30
	Incorrect response	41	
Understanding the mechanism of how a treatment works is more important than having research evidence about the treatment's effect	Correct response	32	70.64
	Incorrect response	77	
There is not enough evidence about the effectiveness of some	Correct response	72	66.05

Continued.

Questions	Responses obtained		
	Answer/responses	Frequency of the response	Percentage of correct respons
physiotherapy treatments. This makes giving/offering options to patients difficult	Incorrect response	37	57.70
Doing shared decision-making is ethical but will increase the length of a visit/consultation	Correct response	46	
	Incorrect response	63	

The knowledge questionnaire about the shared decision making only 4 out of 109 participants answered all questions correctly that is 3.66% of physiotherapist had good knowledge about shared decision making. On an average 93.28% of physiotherapist felt that the shared decision making is necessary in physiotherapy and agreed that use of decision aid and informing patient about condition. On an average 50% of physiotherapists reported shared decision making creates confusion, time constrains and treatment choice restriction. Table 2 represents the responses obtained by participants for knowledge questions on shared decision making.

The attitude of physiotherapist towards shared decision making was assessed using the question how much they believe or agree the use of shared decision making on various conditions measured using Likert scale. Participants agreement for usefulness of shared decision making varied across patient groups. Agreement was highest for chronic musculoskeletal conditions 72%, athletes 70%, and orthopedic cases 65%. Neutral responses were common for ICU 23%, elderly care 12%, and community care 12%. Disagreement was high in ICU settings, with 35% expressing some level of disagreement but remained low in other categories. Figure 1 represents the attitude of physiotherapists towards shared decision making in rehabilitation setting.

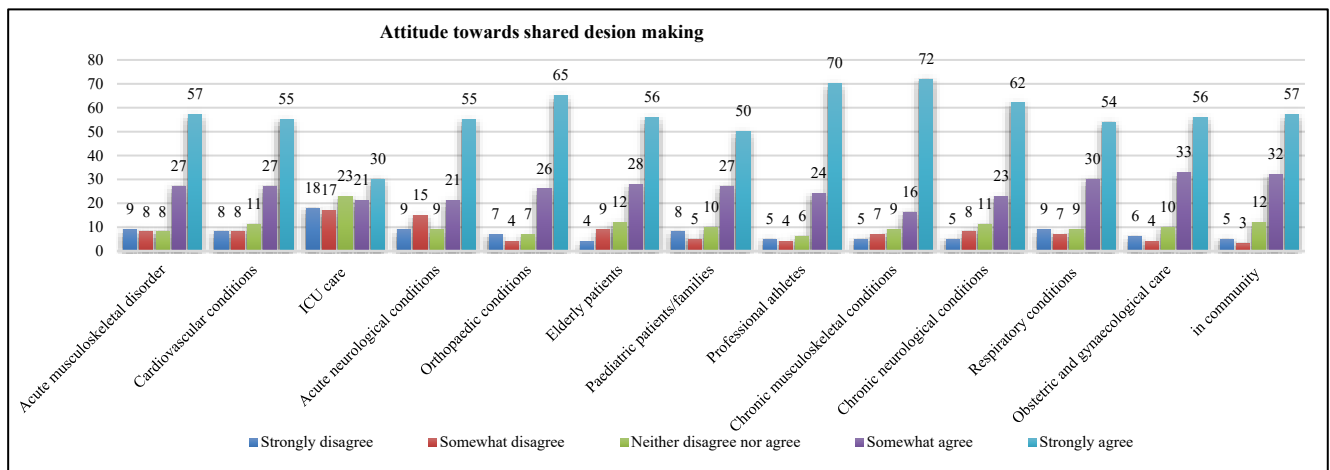


Figure 1: Attitude response of physiotherapist on the concept of shared decision-making usefulness for the rehabilitation treatment planning of various conditions.

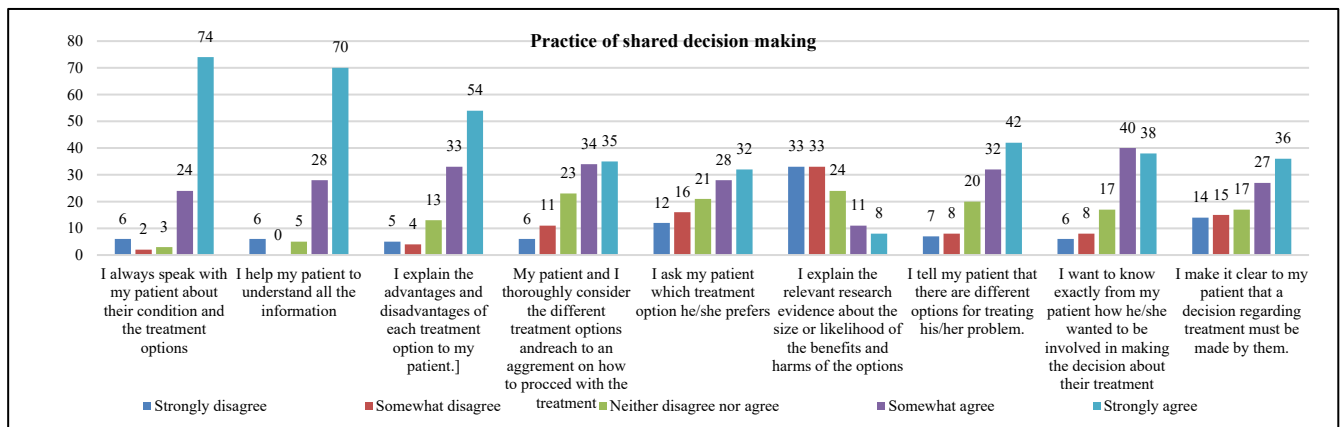


Figure 2: Responses on practice of shared decision-making behavior.

The practice of shared decision making measured using statements related to decision-making behavior in most recent consultation that involved a treatment decision and physiotherapist were asked to indicate how much they agree or disagree that they performed the behavior. self-reported behaviors during recent treatment consultations. There is strong agreement, with 74%, for speaking with patients about their condition, followed by assisting them in understanding information at 70%. Neutral responses are relatively high for considering options and reaching agreements at 23% and asking for patient preferences at 21%. Higher levels of disagreement (both strongly and somewhat) are noted for explaining research evidence on benefits/harms, with a total disagreement of 66%, indicating potential challenges in discussing detailed clinical evidence with patients. Figure 2 represents the responses obtained by physiotherapist on shared decision-making practice.

The study found that only 3.66% of physiotherapists correctly answered all questions on shared decision-making knowledge. Over 50% had a positive attitude towards its usefulness in clinical setting for various conditions. Around 70% agreed to inform and discuss with patients about their condition, while 66% strongly disagreed with its practice in clinical settings based on evidence.

DISCUSSION

To explore the knowledge, attitude and practice of shared decision making among physiotherapist a cross-sectional research design was conducted using the survey method. Participants were recruited based on predefined inclusion and exclusion criteria.

In the study only 3.66% of physiotherapists answered all knowledge questions about shared decision making correctly. The attitude of participants towards shared decision making varied among varies condition and in participation and the behavior of practice varied by having most agreed with behaviours such as discussing patients' conditions, supporting their understanding, and providing general information. Moderate agreement was seen for presenting options, reaching decisions together, and considering patient preferences and explaining research evidence on benefits and harms of treatment had lowest agreement which is almost like the study conducted in Australia in which 19% participants indicated that they had no knowledge of the concept of shared decision making and 2.4% reported comprehensive knowledge and perceived usefulness of shared decision making for treatment decisions for various patient groups showed variation in the extent of agreement and most frequently reported behaviours were reaching an agreement with the patient on how to proceed and speaking with the patient about their circumstances and how these related to treatment options and the behaviour with the lowest reported occurrence was

explaining the relevant research evidence about the size or likelihood of the benefits and harms of the options.¹⁷

The survey conducted on Indian physiotherapists regarding shared decision-making revealed a low level of self-reported comprehensive knowledge but demonstrated a good level of knowledge for most questions. The attitudes of physiotherapists toward shared decision making in various clinical setting varied the fact that only 3.66% of physiotherapists represented knowledge indicates a considerable gap in fundamental understanding. The low shared decision-making knowledge and evidence-based discussion among graduates raises concerns about their capacity to uphold evidence based ethically relevant practice

Even with limited knowledge, 50% physiotherapists self-reported engaging in shared decision making, 93.28% acknowledged its necessity, 50% expressed positive views and about half percentage of participants neutrally agreed on that responsibility for the final treatment decision should be shared between patient and therapist Although 70% discussed conditions with patients, only 23% reviewed evidence collaboratively, and 66% lacked routine evidence-sharing. Explanation of the benefits and harms of treatments with evidence was reportedly lacking in the practice indicating possible challenges in discussing detailed clinical evidence with patients. This gap reflects commonly reported barriers such as confusion, time constraints, and limited treatment options, illustrating the constrains clinicians feel between ideal practice and practical realities. Many physiotherapists view shared decision making as a complex and time-consuming. This disconnect shows the need for targeted education to encourage clinical implementation of shared decision making.

The reported attitude and practice can be influenced by participants perception, cultural norms, and motivation like social desirability.¹⁸ Use of online method of data collection might have led to over or under reporting of practice behaviours.¹⁸ Blinded observational studies on large scale in various physiotherapy practices that explores the barriers and influencing factors shaping attitudes and practices in shared decision-making can overcome this bias.Targeted education and system-level support are essential to translate shared decision making into clinical practice in India.¹⁹

Strength of the study are large sample size of physiotherapist with various areas of practice which enhances the generalizability of the results obtained in the study population. Use of a standardized questionnaire and to assess the knowledge, attitude, and practice of shared decision making.

Limitations

Limitations of this study are the use of an online platform leads to social desirability and high subjective bias.

Controlling number of men and women were challenging due to online survey and convenience sampling leading to overrepresentation of female participants. Additionally, knowledge was assessed using simplistic true or false questions, limiting depth and accuracy of evaluation.

CONCLUSION

Study highlighted a critical gap in the comprehensive knowledge of shared decision-making among Indian physiotherapists, despite a generally positive attitude and partial implementation in practice. While many physiotherapists acknowledge the usefulness of shared decision making across various patient conditions, significant barriers remain particularly in explaining evidence-based benefits and harms during clinical interactions. The findings suggest that a lack of structured training and awareness may be the barriers for adoption of shared decision making in physiotherapy and highlights the need of enhancing physiotherapists' understanding of evidence-based approaches, promoting cultural shifts toward patient-centred care, and integrating shared decision-making education into undergraduate and continuing professional development programs.

Recommendations

Research found that Indian physiotherapists reported low levels of comprehensive knowledge. Lack of knowledge might influence the attitudes and practices regarding shared decision-making behaviour despite low level of knowledge participants agreed on usefulness of shared decision making in various rehabilitation settings and reported of practicing best shared decision-making behaviour which could be because of subjective bias. Future studies should systematically evaluate the knowledge barriers and factors influencing attitudes and practices in shared decision-making behaviour to address gaps in research findings and better understand the reasons behind its limited use in India. More than half of the therapist reported of lack of the use of evidence based clinical decision making with patient which highlights a disconnect between positive attitudes and practical implementation. Targeted education and systemic reforms are needed for effective implementation of shared decision making in Indian physiotherapy practice.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee (reference number JSSCPT/IRC/OS-11/2025-26)

REFERENCES

1. Resnicow K, Catley D, Goggin K, Hawley S, Williams GC. Shared decision making in health care: theoretical perspectives for why it works and for whom. *Med Decision Making*. 2022;42(6):755-64.
2. Elwyn G, Frosch D, Thomson R, Joseph-Williams N, Lloyd A, Kinnersley P, et al. Shared decision making: a model for clinical practice. *J Gen Intern Med*. 2012;27(10):1361-7.
3. Hoffmann T, Bakhit M, Michaleff Z. Shared decision making and physical therapy: What, when, how, and why? *Braz J Phys Ther*. 2022;26(1).
4. Tilak RT, Vidyapeeth M, Tikur R. Ethical and legal considerations for physiotherapy practice in India. *Int J Sci Res*. 2023;12(6).
5. Srinivasan A, Somade O, Shivakumar K. An observational study on assessing involvement of rural Maharashtra adults of Satara district in shared decision-making regarding community health physiotherapy services. *J Soc Indian Physiother*. 2023;7(1):13.
6. Hwee Heng CS. Collaborative goal setting in palliative rehabilitation: a case report. *BMC Palliat Care*. 2024;23(1):179.
7. Pel-Littel RE, Snaterse M, Teppich NM, Buurman BM, van Etten-Jamaludin FS, van Weert JC, et al. Barriers and facilitators for shared decision making in older patients with multiple chronic conditions: a systematic review. *BMC Geriatr*. 2021;21(1):112.
8. Grenfell J, Soundy A. People's experience of shared decision making in musculoskeletal physiotherapy: a systematic review and thematic synthesis. *Behav Sci*. 2022;12(1).
9. Grevnerts HT, Krevers B, Kvist J. Treatment decision-making process after an anterior cruciate ligament injury: patients', orthopaedic surgeons' and physiotherapists' perspectives. *BMC Musculoskelet Disord*. 2022;23(1).
10. Moore CL, Kaplan SL. A framework and resources for shared decision making: opportunities for improved physical therapy outcomes. *Phys Ther*. 2018;98(12):1022-36.
11. Manhas KP, Olson K, Churchill K, Vohra S, Wasylak T. Experiences of shared decision-making in community rehabilitation: a focused ethnography. *BMC Health Serv Res*. 2020;20(1).
12. Mukamel DB, Haeder SF, Weimer DL. Top-down and bottom-up approaches to health care quality: the impacts of regulation and report cards. *Ann Rev Public Health*. 2014;35(1):477-97.
13. Smith CS. Applying a systems oriented ethical decision making framework to mitigating social and structural determinants of health. *Front Oral Health*. 2023;4.
14. Doherr H, Christalle E, Kriston L, Haerter M, Scholl I. Use of the 9-item shared decision making questionnaire (SDM-Q-9 and SDM-Q-Doc) in intervention studies: a systematic review. *PLoS One*. 2017;12(3).
15. Alotaibi MA, Alhowimel AS, Alodaibi FA, Aloraifi M. The practice of shared decision-making among physiotherapists and patients with musculoskeletal conditions. *J Multidiscip Healthc*. 2023;16:2655-2665.

16. Lowe SW, Mackie DW. Shared decision-making in physical therapy: a scoping review. *Phys Ther Rev*. 2025;1-10.
17. Hoffmann T, Gibson E, Barnett C, Maher C. Shared decision making in Australian physiotherapy practice: a survey of knowledge, attitudes, and self-reported use. *PLoS One*. 2021;16(5):1.
18. Choi BC, Pak AW. A catalog of biases in questionnaires. *Preventing chronic disease*. 2004;2(1):A13.
19. Andersson H, Svensson A, Frank C, Rantala A, Holmberg M, Bremer A. Ethics education to support

ethical competence learning in healthcare: an integrative systematic review. *BMC Med Ethics*. 2022;23(1):1.

Cite this article as: Parthasarathi B, Francis SK, Sandeep PH, Raja K. Knowledge, attitude and practice of shared decision-making among Indian physiotherapists. *Int J Community Med Public Health* 2025;12:5159-65.