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RESEARCH ARTICLE

Shared decision making in rural general practices: a qualitative exploration of older rural South Australians' perceived involvement in clinical consultations with doctors

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ABSTRACT

Background: Shared decision-making (SDM) implementation is a priority for Australian health systems, including general practices but it remains complex for specific groups like older rural Australians. We initiated a qualitative study with older rural Australians to explore barriers to and facilitators of SDM in local general practices.
Methods: We conducted a patient-oriented research, partnering with older rural Australians, families, and health service providers in research design. Participants who visited general practices were purposively sampled from five small rural towns in South Australia. A semi-structured interview guide was used for interviews and reflexive thematic coding was conducted.
Results: Telephone interviews were held with 27 participants. Four themes were identified around older rural adults' involvement in SDM: (1) Understanding of "patient involvement"; (2) Positive and negative outcomes; (3) Barriers to SDM; and (4) Facilitators to SDM. Understanding of patient involvement in SDM considerably varied among participants, with some reporting their involvement was contingent on the "opportunity to ask questions" and the "treatment choices" offered to them. Alongside the opportunity for involvement, barriers such as avoidance of cultural care and a lack of continuity of care are new findings. Challenges encountered in SDM implementation also included resource constraints and time limitations in general practices. Rural knowledge of general practitioners and technology integration in consultations were viewed as potential enablers.
Conclusion: Adequate resources and well-defined guidelines about the process should accompany the implementation of SDM in rural general practices of South Australia. Innovative strategies by general practitioners promoting health literacy and culturally-tailored communication approaches could increase older rural Australians' involvement in general.

1. Introduction

"Partnering with Consumers" and "Person-centred Care" are integral to National Safety and Quality Health Service Standards, National Clinical Care Standards, and Aged Care Quality Standards in Australia.[1–3] "Partnering with Consumers" Standard promotes shared decision-making (SDM) in all clinical settings, known for facilitating patient-centred care.[4] SDM is a process that involves healthcare providers and patients working together to make informed decisions about the care.[5–7] By involving patients in the decision-making process, SDM ensures patient safety and autonomy, improves the quality of care and patient satisfaction, and leads to better health outcomes.[5,8] SDM implementation is a priority of Australian health systems, but efforts to gauge the extent to which older Australians experience this dynamic in general practices are few and metropolitan-centric.[9] Our research interest primarily focuses on older rural Australians' (65 years and above) involvement in SDM in general practices.

There is mounting interest in SDM implementation worldwide, and SDM measurement attempts confirm its benefits for healthcare providers and patients. SDM allows patients to be active participants in their

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healthcare journey.[10–12] Rather than simply being passive recipients of clinical advice, patients are empowered to make choices that align with their values and goals. Zheng Y et al. recruited 200 patients from China in 2016 and reported that 88% desired involvement in SDM, and 66% identified decision-making role as their preferred role.[4] Qualitative studies have echoed this aspiration of patients at different stages of their treatment.[13–15] As a collaborative approach, it fosters a sense of ownership and control over one's health, leading to increased patient satisfaction and adherence to treatment plans.[16,17] SDM also promotes the engagement of healthcare providers and patients in open discussions, where patients are encouraged to ask questions, express their concerns, and share their preferences.[18,19] In turn, healthcare providers can provide accurate and comprehensive information, address misconceptions, and tailor their recommendations to patients' unique circumstances. Yet healthcare providers tend to underestimate the involvement of patients in SDM.[20]

The driving forces of SDM implementation are complex and include clinical, socio-demographic, and behavioural factors. The clinical risks factors associated with inadequate SDM implementation are: healthcare providers' lack of understanding of SDM,[21,22] poor physician communication,[22] patient comorbidity or living with degenerative conditions,[23,24] limitations in treatment options,[23,24] and time limitations.[21,23,24] The socio-demographic factors comprising health illiteracy,[4] low academic qualifications,[4] and power differences;[21,25] are blamed for poor SDM outcomes. The behavioural factors are related to avoidance of SDM by healthcare providers and patient passiveness in decision-making.[4,21,23] The links between the elements of SDM implementation are putative and well-embedded in Australia Healthcare Standards and policy initiatives of Royal Australian College of General Practitioners.[1–3,26] Still, healthcare providers and older adults experience challenges and express a need for improvement in SDM implementation, especially in general practices.

The Australian healthcare system is built upon the cornerstone of general practices, often claimed by many older Australians as their first point of contact in the system.[27] In Australia, general practices are usually private medical centres providing "comprehensive, coordinated, and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health".[26,27] General practitioners act as "gatekeepers", referring patients to specialists and allied health professionals based on their service needs.[28,29] One in eight Australians are older adults (4.2 million); in 2019–2020, 3.7 million (95%) saw a general practitioner at least once.[28] There was an increase in general practitioner visits in 2022 than in 2021, which was inclined to old age, long-term health conditions, socio-economic disadvantages, and living in rural and remote areas.[28] In 2022, the ABS reported some common complaints of older Australians about SDM: general practitioners rarely or never listened to them (17.14%), did not show respect (17.15%), and spent inadequate time with them (15.51%).[28] In delivering SDM, general practitioners are unilaterally the decision makers, while older Australians took a passive decision-making role.[15]

The studies are limited in terms of not being inclusive. Available cross-sectional studies show that the SDM does not occur for older Australians regarding treatment options, evidence, and patient preferences.[13,15] Australian studies explored SDM are generally conducted in metropolitan and regional healthcare settings.[13,30–33] National and international studies also unpacked the barriers to involving patients in SDM in diverse clinical settings.[15,32–34] Still, more is needed to know about how the complex systems, processes, and resources of rural general practices are supporting SDM implementation for 34% of older Australians who live in rural and remote areas.

Since 2018, the Government of South Australia has advocated for SDM implementation and evaluation across the state's healthcare settings.[9] Our project was initiated in 2020 in South Australia to promote a culture of shared responsibility between older rural adults and their general practitioners in clinical decision-making, to develop a Patient Activation Toolkit for supporting older rural South Australians. We partnered with older rural Australians, their family members, and local health services partners in order to: (1) explore how older rural Australians identify themselves during the consultations with general practitioners; (2) understand how the older rural Australians' involvement in SDM with general practitioners contribute to their health outcomes and satisfaction with care; and (3) explore the contextual factors that drive the SDM implementation in rural general practices.

2. Methods

2.1. Theoretical assumptions

We base our understanding of SDM implementation in rural general practices on a model developed by Elwyn G et al. in 2012.[35] This model consists of three steps.[35] The first step, choice talk, involves ensuring that patients know their health conditions and reasonable treatment options available to them.[35] The second step, option talk, entails providing more detailed information about these options.[35] The final step, decision talk, is focused on supporting patients in considering their preferences and making the best decision for their situation, considering psychosocial and emotional factors that may influence the SDM process.[35] When exploring patients' involvement in SDM, this model emphasises how they initiate discussions, actively participate, and ultimately contribute to decision-making. Many general practitioners currently use a "one size fits all" approach of short consultations yielding favourable clinical outcomes for older rural Australians. This model can explain why general practitioners cannot support older rural Australians during the deliberation process.[35] We consulted with the health service partners and older Australians and agreed on using this three-step model to elicit evidence on SDM implementation in rural general practices.

2.2. Research design and tools

We conducted a qualitative exploratory study consisting of two major components: (1) patient-oriented research—involving older rural adults, their family carers and local health service partners in the study design; and (2) semi-structured interviews—a collection of data from older rural patients who visited general practitioners recently because of their health conditions.

Ethics approval was obtained from the Flinders University Social and Behavioural Research Ethics Committee (Project number: HREC8252). Principles of patient-oriented research were employed to involve the older rural Australians and their family carers and local health service partners in the research process, including study design, development of interview guide, and data analysis. Our study participants were sampled from five small rural towns in South Australia. The rural towns (Modified Monash Model (MMM) 2019-MM5) were purposefully selected, namely Renmark, Berri, Barmera, Loxton, and Waikerie. Older South Australians living in these rural towns accounted for 25% of the total population in 2016. Most of them were born in Australia, but approximately 58% of those living in the towns moved from overseas (i.e., 126 countries). These older rural South Australians are affiliated with 28 religions, and 85% speak English at home. They were contacted via a local Rotary Club employing different strategies (e.g., emails, rotary club website and local Facebook pages) and provided with an expression of interest (EOI) form.

Older rural South Australians aged 65 years and over were purposively sampled to ensure variation in the age groups, ethnicity, and reasons for general practitioner visits. They were requested to complete an EOI within four weeks from the time of distribution of the EOI form. Interested older rural South Australians were contacted by phone, and a Participation Information Sheet was either emailed or posted. Verbal informed consent was obtained from each participant, with privacy ensured. Those older rural South Australians who did not visit a general practitioner in recent times (within the last three months) or had mental health conditions did not to participate in the interviews.

The study was conducted during the coronavirus disease 2019 pandemic, and to protect our participants, telephone interviews were conducted from June 2021 to November 2021. A semi-structured topic guide was used by the first author (Mohammad Hamiduzzaman) and a research assistant (Judy Bailey), to guide the discussions, and field notes were taken during the interview periods. Participants were asked to share their knowledge and involvement in SDM and discuss facilitators and barriers to patient participation in decision making for older rural South Australians. The findings from older rural South Australians' perspectives regarding these aspects were the focus of this study.

The interviews were audio-recorded (28–43 min in length), and an external Transcription Services Provider transcribed the recordings under a confidentiality agreement. NVivo software was used for coding and analysis. The reflexive thematic analysis method, a contemporary approach developed by Braun V and Clarke V, was applied to identify patterns of meaning across the dataset, with an inductive coding approach and iterative development and reflections on common categories.[36] Data from the interviews were initially coded, and then common nodes were identified across all interviews, leading to the generation of interpretative themes relevant to older rural South Australians. Two researchers (Mohammad Hamiduzzaman and Harry Gaffney) independently coded the data, ensuring consistency, and applied reflexivity in their interpretation. The number of participants and length of interviews provided sufficient coverage of the topic, and saturation was achieved as no new themes emerged during coding. Member checking was not conducted due to constraints, but patient-reported themes were validated by the Patients and their family carer involvement group. The study adhered to the Consolidated Criteria for Reporting Qualitative Research.[37] ensuring transparency and comprehensive reporting of the study methodology.

3. Results

Table 1 displays the characteristics of the 27 participants. On average, the interviews lasted for approximately 22 min.

The analysis of interviews with the older rural adults allowed us to observe patterns in the meaning of participants' experiences and to locate specific examples to elucidate further their perspectives of involvement in SDM. Four themes emerged from reflexive thematic coding and clustering codes into categories, thereby enabling the richness of participant experiences within each of the following themes.

Table 1
Sample characteristics in this study [n (%), $n = 27$].

Demographics	Results
Age group (years)	
65–< 75	17 (63.0)
75–< 85	8 (30.0)
≥ 85	2 (7.0)
Gender	
Female	16 (59.0)
Male	11 (41.0)
Country of birth	
Australia	6 (22.0)
Italy	1 (4.0)
China	1 (4.0)
India	4 (15.0)
Greece	6 (22.0)
Slovenia	1 (4.0)
Turkey	1 (4.0)
Nepal	2 (7.0)
Bangladesh	2 (7.0)
Philippines	3 (11.0)
Educational qualifications	
No formal education	4 (15.0)
Primary school	7 (26.0)
High school	9 (33.0)
Bachelors	4 (15.0)
Master and above	1 (4.0)
Others (certificate, diploma etc.)	2 (7.0)
Language speaking at home	
Speaking English	9 (33.0)
Not speaking English	18 (67.0)

3.1. Theme 1: understanding of "patient involvement" in SDM

The participants described patient involvement as enhancing a patient's understanding of different treatment options by explaining and interpreting information about their disease and prognosis and sharing decisions with their patients. For example: (1) "I guess with me coming out with an answer, whether it's one wants to, whether it's negative or positive, is irrelevant to some form of response to the reason I went to the local general practice in the first place." (Interview 2: Older Rural Women, 67 years old); (2) "I prefer having a wide range of choices. Availability of choices would help me to make informed decisions." (Interview 19: Older Rural Men, 71 years old).

Some participants reported that the opportunity to ask questions was a great way to be involved in their care. This could be during the consultation or being encouraged to write down questions on paper to bring to their consultations. For example: (1) "He (general practitioner) would explain everything, and they didn't. You could ask any questions. No, I would say there's been any difficulty along with my experience." (Interview 10: Older Rural Women, 69 years old); (2) "I had my questions listed and we both (patient and the general practitioner) wrote down the answers. I only agreed with the treatment when I was happy with the answers." (Interview 3: Older Rural Women, 66 years old).

Furthermore, questionnaires to seek the patient's view on their symptoms and management were also thought to be helpful, such as one participant said: "… the new doctor I scheduled an appointment with did not tell me that this could happen. A list of questions would help me to reflect on." (Interview 22: Older Rural Women, 74 years old).

3.2. Theme 2: positive and negative outcomes

Most older rural adults found effective general practitioner-patient communication essential to patient positive health outcomes and satisfaction with care. This facilitated their adherence to treatments and improved rapport for future consultations. As part of effective communication, the older rural adults took on more responsibility for their health and doctors were perceived as more professional: (1) "The doctors were all very professional. Everyone has been very good to me up there." (Interview 14: Older Rural Men, 66 years old); (2) "I mean I'm so happy with my doctor and everything goes along very smoothly." (Interview 23: Older Rural Women, 78 years old).

Others found improved patient and doctor satisfaction through the continuity of care provided by their regular doctors. The more patient background information known by the doctors, the greater the satisfaction with care reported: "We've got very good doctors here and I think they do a very a good job and I have never felt dissatisfied with the way they do things." (Interview 12: Older Rural Women, 79 years old).

Some older rural adults reported dissatisfaction when they felt that their cultural backgrounds and concerns were avoided by their doctors in making treatment decisions. For example: (1) "But other than that, I made all my own appointments and I had to argue with him for an Aboriginal mental health worker because he was just going to send me to where they usually were one so. Yeah, he (general practitioner) didn't take my cultural considerations into effect at all." (Interview 9: Older Rural Women, 68 years old); (2) "Somewhat upset that my concerns hadn't been addressed." (Interview 19: Older Rural Men, 71 years old).

3.3. Theme 3: perceived barriers to SDM

Barriers to shared decision making were mentioned at different levels. Participants often stated that general practitioners had insufficient time. They reported that in situations where the general practitioners

rushed conversations they were unable to "open up" which made meaningful discussion and SDM infeasible. Also, a lack of resources, such as money or personnel, was mentioned frequently as barriers. For example: (1) "I went to my doctor last weekend, and told him, 'Please provide me with the options you believe will help me and your thoughts on the options would help me to make a decision about it.' But time is limited for the consultation. They always seem running late in the appointments." (Interview 26: Older Rural Women, 79 years old); (2) "The only problem is not being able to get into a doctor here." (Interview 5: Older Rural Men, 65 years old).

Others identified the need for continuity of care due to the change of doctors as a barrier. They found their doctors leaving or booked out a long time ahead was a barrier to their doctor-patient therapeutic alliance: (1) "The doctor I saw initially no longer with the clinic, so I then had another doctor explained, so then the whole situation again and it's like, what upset me so. So, I actually said that they were very time consuming." (Interview 1: Older Rural Women, 65 years old); (2) "… when you cannot see your own doctor and need to book an appointment with a doctor completely new to you. Not sure how to involve in confidential discussion with a stranger." (Interview 11: Older Rural Women, 74 years old).

Some older rural adults also mentioned the language and accent of general practitioners as obstacles to participation in discussion: (1) "We have a lot of troops who are from overseas. Some of them had really harsh accents that. It can be difficult to understand what they say." (Interview 1: Older Rural Women, 65 years old); (2) "I don't usually have communication difficulties with anything that I see apart from some of the non-Australian doctors. Shall I put it that way? Sometimes I find it difficult to understand what they are saying to me if they are looking at their computer screen and not at me, right? Okay. But it's really the way that the tone of their voice more than their English is okay, but it's the tone of the voice that I'm finding more difficult to hear unless they are looking at me, right?" (Interview 4: Older Rural Women, 68 years old).

Moreover, some participants reported difficulty hearing a concern. This was either due to the doctor speaking too softly or their hearing impairment. As a result, this increased patients' reliance on speech or lip-reading and written communication. It also increased the patient's dependence on their partners or carers to interpret what was said by their doctor. For example: (1) "A lot of people have difficulty in getting an English-speaking doctor. I think that has been the main concern for a lot because as you get older your hearing isn't good." (Interview 13: Older Rural Women, 71 years old); (2) "When they speak too softly and I'm a bit deaf." (Interview 12: Older Rural Women, 79 years old).

3.4. Theme 4: perceived facilitators to SDM

The older rural South Australians perceived facilitators at the individual level as being specific communication skills to increase patient involvement in consultations. These skills ranged from doctors' writing down the information on paper to repeating the information to optimise patient understanding. For example: (1) "I would say that they should put some of what their requests are or what they expect of you in writing." (Interview 10: Older Rural Women, 69 years old); (2) "… So, you need to make sure by asking them to repeat what you've said of their understanding." (Interview 4: Older Rural Women, 68 years old).

Other perceived facilitators included technology and the Internet. The advantages of rapid information retrieval to enhance the consultation process was reported in one interview: "I've got the facility now to Google it and have a look and see what the responses are to that. I found it a tremendous help to me." (Interview 2: Older Rural Women, 67 years old).

Another participant described the physical space of the practice and its accessibility as a facilitator to shared decision making: "Very accessible facility for everyone, plenty of parking and all that sort of thing. You know parking takes a lot of time—sometimes I missed the first half of my appointments." (Interview 14: Older Rural Men, 66 years old).

One older adult interviewed voiced the need for greater cultural awareness to make Aboriginal people feel more welcomed. This could be through the involvement of an Aboriginal health service or simply facilitating Aboriginal health checks by allowing sufficient time. "As an Aboriginal person, I prefer to see an Aboriginal health service that I know understands what my nature. When I spent 10 min, it was a really rushed consultation." (Interview 9: Older Rural Women, 68 years old).

4. Discussion

4.1. Summary of findings

At a time when "partnering with consumers" and "person-centred care" are integral parts of Australian Healthcare Standards, our study extends previous evidence on the SDM implementation in general practices from the perspectives of older rural South Australians regarding the barriers and potential facilitators to this dynamic. A key finding highlighted the need for an "opportunity to ask questions" and offer "treatment choices" in the deliberation process in rural general practices. Perceived barriers such as doctors' lack of culturally specific care, a lack of continuity of care, and difficulty hearing are among the new findings. The older rural South Australians also discussed resource constraints and time limitations during consultations. In consultations, on the other hand, rural knowledge of doctors and technology integration were viewed as potential enablers for SDM in rural general practices in South Australia.

4.2. Strengths and limitations

The primary strength of our study lies in its focus on the perspective of older rural South Australians regarding SDM implementation in general practices. The research structure was patient-oriented, enabling us to shape the interview questions in collaboration with older Australians, their families, and health service partners. This study also contributes to the literature by identifying and highlighting older rural patients' healthcare needs and expectations, especially those that support SDM and foster patient-doctor relationships. Our study samples were ethnically diverse, therefore accurately reflected the local demographic. However, the sample size was limited, and the purposive sampling method restricted the generalisability of our findings to a broader population. Additionally, our study solely considered older patients' consultations with doctors in rural general practices. In future research, it would be beneficial to include the viewpoints of general practitioners, other healthcare providers and informal caregivers as they play a pivotal role in determining the success of SDM implementation.

Unaffiliated with the participants or clinical background, an independent interview moderator was recruited to facilitate the interviews. Also, data were analysed independently by a doctor (Harry Gaffney) and a researcher (Mohammad Hamiduzzaman) and validated by rural general practitioners, patients, and their family carer involvement group. The inclusion of older rural South Australians proved valuable in gathering significant evidence of the deliberation process and other aspects of general practices. The recruitment through the local Rotary Club ensured a neutral and balanced approach, enabling participants to freely share their experiences without any influence or power imbalances with doctors or researchers. Out of 27 interviews, common themes emerged, and despite actively seeking contradictory views, they were infrequent.

4.3. Comparison with existing literature

Our exploration into the multi-faceted barriers and facilitators that older rural South Australians encounter in SDM has produced some important and insightful findings, many of which echoes in existing academic discourses. A prominent concept that our study highlights align

with the "choice talk" and "option talk" underlined in healthcare literature,[35] emphasising a patient's active involvement in the decision-making process by not just being passive recipients but by asking meaningful questions and evaluating available treatment options.[24,38,39]

A pertinent observation from established research points to general practices trepidations regarding potential medicolegal ramifications, especially while managing cases of multimorbidity.[5] Our study extends this discourse, offering insights into how older patients understand and navigate these medicolegal intricacies. This understanding introduces a new dimension to the conversation, suggesting that such perceptions may be an under-recognised impediment to effective implementation of SDM especially in rural general practices. While previous studies identified perceived power imbalance in doctor-patient relationships, poor communication skills, a lack of clear understanding of SDM and the time pressure as some of the major barriers to SDM.[5] Earlier studies also found that the implementation of SDM was hampered due to clinicians' beliefs as well as cultural and system-level obstacles.[40] The present study adds to these findings from the perspective of older patients living in rural communities. Among others, the current study highlights the role of demographic and context specific factors in the SDM process.

There has been an ongoing debate within the healthcare community about the balance between tailoring personalised care and strictly adhering to clinical guidelines. While there is acknowledgement in the literature about the restrictive nature of clinical guidelines leading to potentially misaligned treatments and polypharmacy,[41] our findings highlight the emphasis older rural South Australians place on the importance of receiving care tailored to their individual needs and circumstances, resonating with sentiments expressed by participants in a study based out of the United States.[42] Also, this reminds the support the older rural South Australians need in the "decision talk" with doctors, in which consideration of the patients' psychosocial and emotional factors is important.[35]

Medical discourses have previously acknowledged the perceived risks associated with decisions that lack a robust evidence base. Yet, our research adds a nuanced layer by emphasising the consequent medicolegal anxieties that often sway general practices towards excessive treatments or inappropriate referrals. This underscores a broader problem: a knowledge gap in understanding and applying decision-support tools and a need for robust guidelines for multimorbidity management.[43]

One novel finding from our study is the emphasis our participants put on the need for clinicians to communicate uncertainties without trepidation. While the literature has consistently championed this need, limited empirical data highlight how clinicians often withhold options with inherent clinical ambiguities, fearful of how patients might react to nebulous information.[44]

Another juxtaposition emerges when exploring doctors' perceived efficacy in facilitating SDM in rural general practices. Even though many feel they excel in this domain, the literature reveals a different reality, our study strongly resonates with a similar sentiment. General practitioners in different studies acknowledged gaps in their proficiency, highlighting the need for targeted SDM training programs.[5] Numerous educational and technological initiatives have been proposed such as on the job SDM training,[45] blended SDM learning with e-learning modules and guided online training session,[46] and artificial intelligence in SDM,[47] yet a tangible, practical guide tailored for daily general practice remains absent in the rural context.

Time, a recurrent theme in our research, is a cornerstone in the SDM process, especially when considering older patients with multimorbidity. Existing studies suggest no direct linear relationship between longer consultations and improved patient outcomes.[48] Our research demonstrates how time constraints frequently impede the depth and quality of patient-doctor interactions in rural context. Although general practitioners desire a manageable workload,[21] the contextual factors in rural areas in Australia like a higher prevalence of chronic diseases (54%) in older rural Australians than their counterparts in major cities (48%),[49] a high number of visits including telehealth services,[50] and limited number of doctors and other healthcare professionals in general practices,[49] complicate the SDM implementation.

Overall, continuity of care emerges as a unifying theme, both in our study and the broader literature, as a significant enabler of SDM. This reflects a shared conviction among patients, practitioners, and academic experts about the inestimable value of continuity in cultivating a solid foundation for SDM.

4.4. Implications for research and practice

SDM is espoused as a hallmark of personalised and patient-centred care, and an ethical imperative. It is associated with many positive outcomes including improved patient-clinician communication, better health outcome and patient satisfaction. Despite growing evidence demonstrating the beneficial impacts of patient engagement in health decision making SDM is not widely practiced in Australia, especially at the primary healthcare setting in rural areas.

Rural areas are home to a third of older Australians. They differ from younger patients in terms of healthcare needs and preferences. Due to poor health and physical and cognitive impairments, they experience a unique set of challenges and may have different expectations from their clinicians. This study explores the state of SDM as perceived and experienced by older patients living in rural communities in South Australia. It shows that there is a need for a more nuanced understanding and awareness about SDM at primary healthcare level for the clinicians to be able to accommodate the unique preferences and needs of older rural patients with co-morbidity.

Since Australia is lagging behind many other countries virtually in all major areas of SDM including policies, advocacy and lobbying, research funding, education and training we feel that there is a pressing need for concerted efforts to put this firmly on the agenda and to advance SDM in clinical settings at all levels. This underscores the importance of measures like promoting awareness and competency among general practitioners and other health professionals especially at primary care levels. It is a high time that relevant institutions begin to prioritise and plan to incorporate SDM as a core aspect of training and educational programs in healthcare management and delivery. Similarly, there is need to rethink and refine the guidelines for clinicians when dealing with vulnerable groups like older patents.

Most participants in our study reported time pressure/short consultation period as well as the lack of continuity in care as some of the impediments to SDM, findings that broadly align with those of other studies elsewhere. Therefore, the policy makers and those in healthcare management should consider organisational strategies that support adequate duration for consultation and relational continuity between older patients and their doctors. Mandating the "ask 3 questions" approach as followed in many contexts internationally may go some way towards addressing the challenges facing this client group. This expressly invites and encourages the patients to ask questions to health professionals. This can greatly facilitate SDM in situations where patients hesitate to ask questions on their own, and where they are unaware of the primacy of the role, they have in SDM.

5. Conclusion

To the best of our knowledge, this study is the first of its kind, delving into the experiences and viewpoints of older South Australians regarding SDM implementation in rural general practices. Our research findings offer updated insights into the barriers and facilitators of SDM implementation from a rural lens, confirming and reinforcing previous study conclusions, as well as open windows to further research. Notably, our study underscores the significance of educational interventions for older adults and general practitioners. While the findings may not be readily applicable to other population groups or regions, the perspectives of policymakers shed crucial light on unexpected and context-specific factors

influencing SDM implementation in South Australia. This valuable information serves as a vital foundation for developing and testing Patient Activation implementation strategies, aiming to enhance SDM practices and patient engagement in the healthcare decision making process.

Ethics approval and consent to participate

The study received ethics approval from Flinders University Human Research Ethics Committee, Australia (Project number: HREC8252). All informants gave audio recorded verbal consent to participate prior to interviews.

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CRediT authorship contribution statement

Mohammad Hamiduzzaman: Conceptualization, Methodology, Data curation, Project administration, Formal analysis, Visualization, Writing – original draft. **Noore Siddiquee:** Conceptualization, Project administration, Formal analysis, Writing – original draft, Writing – review & editing, Funding acquisition. **Harry James Gaffney:** Formal analysis, Writing – original draft, Writing – review & editing, Validation. **Frances Barraclough:** Writing – review & editing, Validation, Investigation, Conceptualization. **Aziz Rahman:** Conceptualization, Writing – review & editing, Validation. **Jennene Greenhill:** Conceptualization, Writing – review & editing, Validation. **Vicki Flood:** Conceptualization, Writing – review & editing, Validation.

Competing interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Availability of data and materials

The datasets generated during this study are not publicly available due to the sensitive and personal nature of the information contained in the data. Data may be available from the corresponding author, with restrictions and following ethical approval.

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