

Do patients want to be involved in treatment decisions

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Abstract

In recent years, the increased accessibility to information has resulted in patients and their relatives becoming more familiar with medical issues and perhaps desiring a more prominent role in treatment decisions. A study of the extent of involvement that orthopaedic patients wanted in decisions regarding their treatment showed that the majority (84%) wanted significant decisions regarding their treatment to rest with their attending doctor. Whether this is characteristic when an individual assumes the sick role or a result of being inadequately informed remains to be determined.

Key Words: Patient involvement, treatment decisions, treatment choice

Introduction

The law of informed consent seeks to actively involve patients in decision making (Lidz *et al.*, 1983). The right to consent to or decline a particular treatment option is based on the ethical principal of autonomy. Respect for patients' autonomy requires that the patient is informed of all possible respective outcomes of a particular treatment option and is allowed to make an assessment of the quality of life associated with these outcomes (Casali *et al.*, 1997).

In recent years, the increased availability to information via the media has resulted in patients and their relatives becoming relatively more informed of medical issues, and apparently desiring an increasing role in treatment decisions. Although increased information furnished to patients has been associated with improved outcomes (Bader & Brarde, 1998; Hornberger *et al.*, 1994) and involvement with decisions regarding their treatment has improved patient satisfaction (Hornberger *et al.*, 1994), it is controversial whether all patients are capable of, or, are prepared to make significant decisions regarding their treatment.

Patients may feel threatened when requested to make decisions regarding their treatment. They may view this as the shirking of clinical and medico-legal responsibility

by attending clinicians especially when constraints of time and work load commitment, compromise the required amount of unhurried communication between clinicians and, patients and their relatives. Further they may not have the required background understanding of clinical issues to bear the responsibility for treatment decisions.

To evaluate whether patients considered or perceived that, they had ample opportunity to, and whether they were prepared to make decisions regarding their treatment, a study was performed on patients admitted for treatment by the Department of Orthopaedics of a Malaysian Government Hospital, the clinical workload of which is shown in Table 1.

Materials and Methods

One hundred consecutive adult patients whose condition could be treated by more than one accepted standard method or procedure were identified and included. All had non-immediately life threatening conditions. The attending clinicians (doctors, nurses and medical assistants) involved in patient care were blinded as to which patients were included. The patients were interviewed in the initial instance before their treatment pro-

Table 1. Departmental clinical workload

	Year	
	1996	1997
No. of allocated beds	132	124
No. of annual outpatient attendances	25502	26571
No. of annual inpatient admissions	4121	4197
No. of operative procedures (annually)	2746	2770
Average No. of patients per outpatient clinic session	257 ± 28.4	279 ± 26.75
Average No. of daily inpatient admissions	11.24 ± 1.09	11.36 ± 1.25
Average length of inpatient stay (days)	5.20 ± 0.70	5.17 ± 0.74

cedure and then, again after the procedure. The interviews were conducted by a clinician whom the patients had not previously met, who was not involved in their treatment and who was blinded as to the respective conditions of the patients.

Information was sought from the patients as to whether they had received adequate information about their condition, whether they had the opportunity of being involved in treatment decisions and the extent they were prepared to be involved in decisions regarding treatment as shown in Table 2 (before treatment) and Table 3 (after treatment).

Results & Discussion

With the altruistic attitude to fulfill the needs of patients in wanting to be involved in decisions regarding their treatment, and perhaps influenced by legislation, clinicians are continuously attempting to incorporate patient participation in treatment decisions. However widespread patient involvement in treatment decisions is uncommon (Lidz *et al.*, 1983).

Although 97% and 94% of the patients in the study indicated that they had received adequate information on diagnosis and natural history, and treatment options respectively, only 68% indicated that the information received was adequate for their participation in treatment decisions. The reason for this discrepancy is un-

clear. Perhaps it reflects lack of confidence on the part of some of the patients to participate in treatment decisions with the blame being rendered on having insufficient information to do so.

At the initial interview, prior to their treatment procedure, only 43% of the patients indicated that they had ample opportunity of being involved in treatment decisions. The majority (57%) indicated that they did not. Perhaps the patients did not have sufficient background knowledge and understanding, and information furnished by their attending clinicians was insufficient. However 68% of the patients indicated that they had received adequate information for participation in treatment decisions and only 32% indicated they did not.

The attending clinicians, perhaps because of time and workload constraints may not have appeared to provide ample opportunity for patient participation in treatment decisions, by formally and repeatedly seeking patients views and opinions. Only 49% of the patients indicated that the nature and risks of complications was adequately explained. This possibly depicts the shortcomings of the clinicians in not ensuring effective adequate communication and impartment of information, and, or the patients inability to comprehend clinical issues.

Although 57% of the patients indicated that they did not have the opportunity to be involved in treat-

Table 2. Facts on aspects of management sought from patients during initial interview prior to treatment procedure

Facts sought	n = 100	
	Yes %	No %
Diagnosis & natural history adequately explained	97	3
Treatment options adequately explained	94	6
Risks & nature of complications adequately explained	49	51
Information provided adequate to make treatment decisions	68	32
Opportunity to be involved in treatment decisions adequate	43	57
Felt uneasy because too much information was provided	10	90

Table 3. Facts on aspects of management sought from patient during subsequent interview after subsequent interview

Facts sought	n = 100	
	Yes %	No %
Information about treatment adequate	92	8
Treatment adequate & appropriate	89	11
Happy with opportunity to be involved in treatment decisions	87	13
Final or major decision should rest on doctor	84	16
Final or major decision should rest on patient	16	84

ment decisions only 32% indicated that they did not have adequate information to do so. Lack of adequate information was possibly and probably not the sole factor responsible for the patients' apparent lack of opportunity to participate in treatment decisions.

Clinicians are duty bound, not to reflexly accept and institute patients' requests, but to place these requests alongside other medical, prognostic, ethical and legal policy issues (Asch *et al.*, 1995). When patients' requests are not complied with by clinicians, they may be perceived to be hindering patient requests and patient participation in treatment decisions.

Although, at the initial interview prior to the treatment procedure, only 43% of the patients indicated that they had the opportunity to participate in treatment decisions, twice as many (87%) indicated that they were happy they had the opportunity to participate in treatment decisions when they were interviewed again after the treatment procedure. A reason for this two fold discrepancy between the initial and second interviews could possibly be that the patients have had the time to assimilate and better understand clinical issues prior to the second interview and were in a better position, to recognise that there was ample opportunity for their involvement in treatment decisions. Also, having undergone the treatment procedure may have enabled them to better understand clinical issues regarding their treatment.

The majority (84%) of the patients in the study indicated that the final decision regarding their treatment should rest with the doctor. This draws similarities with the work of Davidson *et al.* (1995), where the majority of patients in their study wanted only to be informed of the treatment decisions and wanted the final decision to be made by their physicians. It is also in accordance with the observation by Lidz *et al.* (1983) that although most patients want information about treatment, they typically believe that decision making is the physician's task.

The responses obtained from the patients in our study population indicate that they were not prepared to be responsible for decisions regarding their treatment as 84% indicated that the final treatment decision should rest with the doctor. Also, the two fold rise in the number of patients, from 43% to 87% who indicated that they had the opportunity to be involved in treatment decisions when interviewed before and after the treatment procedure respectively, may possibly reflect denial of the opportunity to be involved in treatment decisions prior to their treatment because they were not prepared to be involved. Whether the reluctance of being involved in treatment decisions is an intrinsic personality trait of patients when they assume the sick role or whether it is extrinsic, due to inadequate information, inadequate opportunity or sociocultural factors, remains to be de-

termined.

This reluctance of being involved in treatment decisions may perhaps diminish in future, as clinicians continue to educate and encourage their patients through increasingly comprehensive communication to assume increasingly significant roles in treatment decisions.

Although this study was performed on patients with non immediately life threatening orthopaedic conditions, where emotional and sensitive issues are possibly less predominant, it has its limitations. They were, the small sample size, and selection bias, in that the sample population was drawn from patients admitted for treatment by a single speciality department at a public hospital.

Although the widespread dissemination of information has resulted in patients and their relatives being exposed to increasing information and resulted in apparent enthusiasm for participation in treatment decisions, this study on orthopaedic patients has shown that the majority (84%) of patients feel that the final decision regarding their treatment should rest with the doctor. Whether this attitude is due to "intrinsic" patient characteristics when they assume the sick role, or has come about because of ineffective communication and inadequate impartment of information remains to be determined.

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