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Chapter 4

DUTCH DENTISTS' VIEWS OF INFORMED CONSENT: A REPLICATION STUDY[1]

1 Introduction

In the Netherlands, the doctrine of informed consent was legally established in April 1995, when the Dutch government introduced the Medical Treatment Contract Act. This act aims to strengthen and clarify the position of the patient, by establishing the rights and duties of both patient and practitioner. A central aspect of this act is the patient's right to information about the treatment and its consequences, as is the obligation of the practitioner to ask for the patient's consent to the proposed treatment. Together, they form the doctrine of informed consent.

Results from two prior studies suggest that Dutch dentists do have problems with the implementation of some of the requirements of this act in practice. For example, many dentists indicate that they do not have enough time to inform their patients adequately about the treatment. Moreover, they report that they lack some of the communicative skills necessary to meet the obligation of the doctrine of informed consent (Schouten, Eijkman, Hoogstraten & den Dekker, 2001; Eijkman & Goedhart, 1996). Both dentists' negative attitudes towards this act and their lack of communicative skills could have negative consequences for the amount of information patients receive, and hence, for patients' ability to make an informed decision about the treatment.

Unfortunately, due to the qualitative nature of the study by Eijkman and Goedhart (1995) and the relatively low response rate in the study by Schouten et al. (2001), the extent to which the results of these studies can be generalized is uncertain. For example, the low response rate of the latter study may be due to a lack of interest by dentists with respect to the matter of informed consent. It is

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also possible, though, that dentists did not respond out of a general aversion towards legislation. Support for this last possibility comes from a study by Gorter, Albrecht, Hoogstraten and Eijkman (1999), which found that dentists feel pressured by governmental interference and that this is a major stressor in dental practice. Hence, the results of the study by Schouten et al. (2001) may be biased in positive direction, because it is plausible to assume that dentists interested in the topic responded more than dentists who are not interested.

Another possibility for the low response rate is the use of a rather long questionnaire, which may have kept dentists from filling it out, regardless of their interest in the topic. Therefore, it was decided to replicate the former study with a strongly shortened and somewhat adjusted version of the original questionnaire. If the results of this replication study are consistent with the results of the original study, more confidence will be gained in the tenability of the hypotheses of the original study (Judd, Smith & Kidder, 1991) and results can be generalized with more certainty (Hoogstraten, 1999; Nieliep, 1991). Thus, aims were the same as in the Schouten et al. study (2001), namely to assess dentists' knowledge, attitudes and self-efficacy towards informed consent.

2 Material and methods

The material consisted of a shortened and adjusted version of the questionnaire used in the study by Schouten et al. (2001). Knowledge of dentists was simply assessed by asking them to indicate whether or not they are aware of the principle of informed consent. Their attitudes were measured by means of a scale, comprising six statements, which had to be answered on a 5-point Likert scale, ranging from 1 ('totally disagree') to 5 ('totally agree'). Three statements concerned possible positive consequences of the requirements of informed consent, three statements concerned possible negative consequences. Total scale score ranges from 6 to 30, with higher scores indicating more positive attitudes.

Dentists' self-efficacy was determined by six items, which for the greater part concerned self-efficacy toward informing specific groups of patients, such as children and immigrants. Items had to be answered on a 5-point Likert scale, ranging from 1 ('very hard') to 5 ('very easy'). Total scale score ranges from 6 to 30, with higher scores indicating higher levels of perceived self-efficacy. Furthermore, dentists' age, their gender and number of years working as a dentist were assessed.

The questionnaire was sent to 384 Dutch dentists, drawn random from the registers of the Dutch Dental Association. The response rate was 60.2% (n = 231), of which 80.5% men and 19.5% women. Mean age of the dentists is 42.4 years (sd=9.7; range 23-62) and they work on average 15.5 years as a dentist (sd=9.3). A

majority of the respondents works in their own practice (71.6%) for on average 34.8 hours a week. 78.4% Of them is a member of the Dutch Dental Association.

3 Results

A majority of the respondents indicated that they are acquainted with the Medical Treatment Contract Act (86.6%), as well as with the principle of informed consent (78.1%). Table 1 shows the mean item scores on the attitude scale. As can be seen from the table, mean scores on items regarding perceived negative consequences of informed consent are somewhat higher than mean scores on items regarding perceived positive consequences of informed consent. On the whole, scores are on the neutral to negative end of the scale. Mean scale score on the attitude scale is 16.7 (sd=3.7; Cronbach's alpha=.63).

Table 1 Mean item scores on attitude scale in the replication study

Item: The principle of informed consent:	**N**	**Mean**	**sd**
• enhances the cooperation between dentist and patient	230	3.2	1.0
• enhances the patient's awareness of the condition of his teeth	230	3.1	1.0
• enhances the quality of care	230	2.9	1.0
• leads to greater time-pressure	228	3.3	1.4
• leads to a commercialization of the dentist-patient relationship	226	3.6	1.2
• makes it more likely that dentists will safeguard themselves against legal procedures	230	4.0	0.9

To compare the results of this study with the results of the original study, mean item scores on the relevant attitude items of the first study are given in table 2. Even though the items were slightly different formulated in the original study, it is clear that the results concerning respondents' attitudes towards informed consent are highly comparable in both studies.

Table 2 Mean item scores on attitude scale in the original study

Item	N	Mean	sd
• the duty to inform the patient enhances the cooperation between dentist and patient	251	3.0	1.0
• the duty to inform the patient enhances the patient's awareness of the condition of his teeth	252	3.0	1.1
• the duty to inform the patient enhances the quality of care	249	3.2	1.1
• it takes too much time to inform patients properly	251	3.5	1.1
• the duty to obtain the patient's consent leads to a commercialization of the dentist-patient relationship	249	3.5	1.1
• the duty to obtain the patient's consent makes it more likely that dentists will safeguard themselves against legal procedures	252	3.8	0.8

In table 3 mean item scores on the self-efficacy scale are shown. As can be seen from the table, respondents find it easiest to inform higher educated people about the treatment. Informing immigrant people is relatively hard, according to the respondents. Mean scores on the other items are roughly in the middle of possible scale scores. Mean scale score on the self-efficacy scale is 18.1 (sd=3.2; Cronbach's alpha=.69).

Table 3 Mean item scores on self-efficacy scale in the replication study

Item: Please indicate how easy/hard you find it to:	N	Mean	sd
• inform immigrant patients about the treatment	227	2.1	0.8
• answer all questions of patients	229	3.2	0.9
• inform lower educated patients about the treatment	230	3.0	0.9
• keep up with all recent developments within dentistry	230	2.9	0.8
• inform children about the treatment	227	3.2	0.9
• inform higher educated people about the treatment	229	3.7	0.8

Table 4 shows the results obtained in the original study on the relevant self-efficacy items. When comparing both tables, it can be seen that there are no major differences between both scores, even though items in both studies were not exactly identical.

Table 4 Mean item scores on self-efficacy scale in the original study

Item	N	Mean	sd
• I find it difficult to inform immigrant people	250	4.2	0.9
• I am sufficiently trained in communicative skills to answer all questions of patients	253	3.6	0.9
• I do not find it difficult to inform lower educated people	254	3.6	1.0
• I cannot answer all questions of patients, because I am not aware of all recent developments within dentistry	251	2.3	1.0
• I find it easy to inform children about the treatment	253	3.5	0.9

To test if dentists' knowledge, attitudes and perceived self-efficacy were associated, correlation coefficients were calculated and t-tests were carried out. It turned out that dentists' knowledge and their attitudes were not associated. However, mean scores on the self-efficacy scale of dentists who are acquainted with the principle of informed consent are significantly lower than mean scores of dentists who are not acquainted with this principle (t-test; t(-2.1); p=.036). Furthermore, the correlation between scores on the attitude – and self-efficacy scale reached significance (Pearson's r=.27; p<.001).

Finally, the relationship of several background variables with dentists' knowledge, attitudes and self-efficacy was explored. Results show that dentists who work in their own practice are less often acquainted with the principle of informed consent as opposed to dentists who work in employment (chi^2(5.2); p=.02). Furthermore, younger dentists are more often aware of the principle of informed consent than their older colleague's, perhaps because younger dentists have received more education during their training as a dentist (chi^2(11.2); p=.004). Other background variables, such as gender and number of years working as a dentist, were unrelated to dentists' attitudes, self-efficacy and knowledge.

4 Discussion

This replication study was carried out in order to test whether the response rate would be higher when using a shorter version of the original questionnaire. This was indeed the case. Response rate was approximately 20% higher than the response rate in the original study, indicating that the length of the questionnaire was an important factor in keeping response low. However, in spite of the short length of the questionnaire used in this study, a considerable minority of the

dentists did not respond. Thus, other motives must underlie their unwillingness to take part in the study and, therefore, it should be kept in mind that results still could be biased.

Fortunately, the results of this study do point in the same direction as the results of the first study, thereby increasing the confidence in the outcomes. For example, in both studies most dentists are acquainted with the Medical Treatment Contract Act, although specific knowledge of informed consent turned out to be somewhat lower. Also, dentists' attitudes and perceived self-efficacy are about the same in the two studies. Furthermore, the strength of the correlation between attitudes and self-efficacy is more or less similar, as is the lack of association between knowledge and attitudes.

The fact that the results of both studies show that dentists still have problems with some aspects of informed consent, once again demonstrates the importance of continuously educating dentists on this topic. Specifically, dentists' fear for legal procedures and the difficulty they have with informing immigrant patients warrants further attention. Problems with regard to informing immigrants should be discussed and skills to improve this specific interaction trained.

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