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Chapter 8

DENTAL PATIENTS' NEED FOR INFORMATION AND PARTICIPATION IN MEDICAL DECISION MAKING¹

1 Introduction

Since the introduction of the Medical Treatment Contract Act in April 1995 by the Dutch Parliament, Dutch physicians have not only a moral but also a legal obligation to adequately inform their patients and to involve them in medical decision-making. Morally, this obligation is rooted in the principle of autonomy, which means that patients have the right but also the responsibility to control their own body and soul (Wear, 1993; Faden & Beauchamp, 1986). Legally, patients' right to self-determination is asserted in the requisites of informed consent, one of the most important elements of the Medical Treatment Contract Act.

Despite the indisputable shift in dogma toward patient autonomy and away from medical paternalism, the question remains whether patients really want to be involved in their own medical care, and if so, to what extent. Although several studies have demonstrated that many patients desire almost as much information about their condition as possible, and moreover, that doctors have a tendency to underestimate patients' need for information (Davis, Hoffman, & Hsu, 1999; Fallowfield, Ford & Lewis, 1995; Nease & Blair Brooks, 1995; Beisecker & Beisecker, 1990; Ende, Kazis, Ash & Moskowitz, 1989; Sutherland, Llewellyn-Thomas, Lockwood, Tritchler & Till, 1989; Blanchard, Labrecque, Ruckdeschel & Blanchard, 1988; Waitzkin, 1985), the results regarding patients' desire to participate in medical decision-making are not that clear-cut. Most studies have found that patients, regardless of their high desire for information, rather leave

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decisions to their physicians (Nease & Blair Brooks, 1995; Degner & Sloan, 1992; Siminoff & Fetting, 1991; Beisecker & Beisecker, 1990; Ende et al., 1989; Sutherland et al., 1989; Blanchard et al., 1988), but other researchers assert just the opposite (e.g. Haug & Lavin, 1981). Within dentistry, only a few studies were carried out assessing patients' need for information. These studies also found that dental patients desire detailed information on a variety of dental topics and, besides, that they are not always satisfied with the amount of information they receive from their dentist (Adekoya-Sofowora, Lee & Humphris, 1996; Harych & Völkel, 1990; Eijkman, van Riel & van Dijk, 1984).

Deber (1994) has argued that the seemingly low interest of many patients in making decisions is partly due 'because the studies have not clearly defined 'participation' and have confused two dimensions of choice' (p. 425-426), which she terms 'decision-making' and 'problem-solving'. Deber defines problem-solving as identifying the correct solution to a problem, whereas decision-making involves making a choice between several alternatives. According to Deber, patients seldom will be involved in the problem-solving phase, because these tasks require medical expertise and knowledge. On the other hand, the ultimate choice of action to be taken lies of course in the hands of the patient. Although decision-making often requires prior problem-solving, values and preferences of patients determine which decision will be taken.

These hypotheses were tested in a survey among patients undergoing angiogram (Deber, Kraetschmer & Irvine, 1996), and the results indeed confirm that most of the patients did not want to be involved in problem-solving tasks, but that they did wish to have control over the decisions to be taken. Of course, more research is needed to verify these results in different settings and with different populations. Therefore, one of the aims of the present study is to determine patients' need for involvement in problem-solving, as well as decision-making tasks, within a dental setting.

Another aspect which complicates drawing final conclusions regarding patients' need for information and, in particular, their desire for participation in medical decision-making is the influence of personality and demographic characteristics of patients. Numerous studies have shown that patients' age, education and gender are related to the amount of information and participation patients prefer. Older age, lower education and male gender are not only more likely to be associated with less need for information and participation, these groups of patients also tend to search for and receive less information and involvement in medical decision-making (Davis, Hoffman & Hsu, 1999; Turk-Charles, Meyerowitz & Gatz, 1997; Deber, Kraetschmer & Irvine, 1996; Street, Voigt, Geyer, Manning & Swanson, 1995; Fallowfield, Ford & Lewis, 1995;

Nease & Blair Brooks, 1995; Degner & Sloan, 1992; Beisecker & Beisecker, 1990; Weisman & Teitelbaum, 1989; Ende et al., 1989; Waitzkin, 1985).

A personality trait much studied in the present context is patients' coping style, that is, the tendency to either seek information about potentially threatening situations (monitoring) or distract oneself and avoid information (blunting). It seems likely that satisfaction with the amount of information provided is lower among people with a monitoring style of coping than among people with a blunting style of coping. This is indeed what several studies have found (Miller, 1995; van Zuuren & van Straten, 1991; Miller, 1987). However, counter-intuitively, high monitoring is not necessarily related to an increased need for participation in medical decision-making. In a review on copingstyle among cancer patients, Miller (1995) reported that high monitors in general desired less participation in decision-making than low monitors. According to Miller, a possible explanation for this finding is that being involved in decision-making interferes with obtaining relevant information from the physician.

The Threatening Medical Situations Inventory (TMSI) does assess patients' copingstyle within the domain of threatening medical situations (van Zuuren & Hanewald, 1993). Studies on the psychometric qualities of this instrument have shown evidence for satisfactory internal consistency and factor-structure, as well as convergent and discriminant validity (van Zuuren, de Groot, Mulder & Muris, 1996; van Zuuren & Hanewald, 1993). The predictive validity of the TMSI though, has not yet been demonstrated thoroughly. In a study on cancer patients' copingstyles, it was found that a monitoring style, as assessed with the TMSI, was positively correlated with a preference for detailed information and participation in medical decision-making (Ong, Visser, van Zuuren, Rietbroek, Lammes & de Haes, 1999). More research, however, is needed to confirm these results.

The present article reports on the results of two surveys, which both studied dental patients' need for information and participation in medical decision-making. The first survey made use of a sample of dental patients receiving treatment during emergency consulting hours, in most cases not from their own dentist. The sample in the second survey consisted of regular dental patients who visited their own dentist during normal visiting hours. The purpose of the study was to determine levels of preference for information and participation among these two groups of patients, and the intermediate effect of demographic variables and patients' copingstyle. In line with previous research, it is hypothesized that female gender, higher education, younger age and a monitoring copingstyle are positively associated with higher needs for information and participation in medical decision-making. Furthermore, it is hypothesized that patients' desire for participation in general will be lower than their desire for

information, but that patients do prefer involvement in decision-making tasks as opposed to involvement in problem-solving tasks.

2 Material and methods

2.1 Subjects

The first survey was conducted in 13 different Dutch dental private or group practices, located in different communities around the country. From each practice one dentist participated in the project. Mean age of these 13 dentists is 45.4 years ($sd=5.2$; range 38-60), they are practicing dentistry for on average 19.0 years (range 8-34), and work on average 32.9 hours a week (range 23-45). The mean number of patients visiting them at least once a year is 1903. Seven dentists reported that they did follow some post-graduate courses on dentist-patient communication.

To be enrolled in the study, patients had to be older than 16 years, and had to be able to speak and read the Dutch language. When these criteria were met, patients visiting the dentist for emergency treatment were asked, in the waiting room before undergoing treatment, if they were willing to participate in the study. All patients signed consent forms indicating their willingness to participate and their understanding of the procedure and general aim of the study.

The second survey was carried out in five of the same dental practices of the first survey. Each practice received a hundred questionnaires. The dental assistant or receptionist was instructed to administer these questionnaires to their patients during one week or until no questionnaires were left. Regular patients, who were visiting their dentist during normal visiting hours for treatment or routine check-up, were asked to fill out the questionnaire immediately after treatment. Also, they were shortly explained about the study goals.

Mean age of these five dentists is 47.2 years ($sd=5.1$; range 38-51), they are practicing dentistry for on average 20.1 years (range 8-26), and work on average 36.1 hours a week (range 32-45). The mean number of patients visiting them at least once a year is 2309. Finally, three dentists followed some post-graduate courses on dentist-patient communication.

2.2 Questionnaires

Data for each patient were collected using a questionnaire administered after treatment, assessing patient's copingstyle and their need for information and participation, which patients from survey one had to fill out at home and return within two weeks after treatment. Patients from survey two filled out the questionnaire immediately after treatment.

The questionnaire included the following scales: the Threatening Medical Situations Inventory (TMSI) (Miller, 1987) to assess patients' copingstyle, the subscale 'Information' of the Krantz' Health Opinion Survey (HOS) (Krantz, Baum & Wideman, 1980) and the subscale 'Information-seeking preference' of the Autonomy Preference Index (API) (Ende et al., 1989) to assess patients' need for information, and part of the subscale 'Decision-making preference' of the API and the Deber-Kraetschmer Problem-Solving Decision-Making scale (PSDM) (Deber, Kraetschmer & Irvine, 1996) to assess patients' need for participation in medical decision-making.

The TMSI consists of four scenarios of threatening medical situations, for example having to undergo uncertain heart surgery, followed by three monitoring and three blunting alternatives. Each of these alternatives has to be answered on a 5-point Likert scale, ranging from 1 ('not at all applicable to me') to 5 ('strongly applicable to me'). Total monitoring and blunting scores are obtained by adding up the relevant items (range for both scales 12-60).

The subscale 'Information' of the HOS consists of seven items, which measure patients' desire to be informed about the treatment. Responses are rated in a binary, agree-disagree format. A high score indicates an active attitude toward being informed about the treatment. The reported reliability of the subscale is good (Kuder-Richardson reliability around .75). The second instrument used to measure patients' need for information is the subscale 'Information-seeking preference' of the API, which includes eight items. Response choices range from 1 ('strongly disagree') to 5 ('strongly agree'). Total scores are linearly adjusted to range from 0 to 100, where 0 indicates no desire for information and 100 the strongest possible desire for information. The reported test-retest reliability is .83, the internal consistency coefficient (Cronbach's alpha) is .82 (Ende et al., 1989).

Finally, part of the subscale 'Decision-making preference' of the API and the PSDM scale were used to measure patients' need for participation. The original 'Decision-making preference' subscale consists of a six item-scale plus nine items relating to three clinical vignettes. Because the nine vignette items and one of the scale items were not relevant for the dental setting, only five items from the scale were used in the present study. The PSDM scale contains three brief vignettes, followed by six series of tasks, four of them relating to problem-solving activities, and two relating to decision-making activities. The four problem-solving tasks encompass determining the diagnosis, treatment options, risks and benefits and probability of risks and benefits. The two decision-making tasks refer to deciding about accepting the risks and benefits and selecting the ultimate treatment option. Respondents are asked to indicate on a 5-point scale who should decide for each task. Answer possibilities are: 1, the doctor alone; 2,

mostly the doctor; 3, both equally; 4, mostly me; 5, me alone. Reported internal consistency of the scales is satisfactory (Cronbach's $\alpha > .70$).

For the purpose of the present study two vignettes were used. The first vignette reads, 'suppose you had mild tooth pain for some days during tooth brushing. Besides that, the tooth doesn't trouble you. You decide to visit your dentist about this'. Vignette two reads, 'suppose that, for the last couple of days, one of your teeth is becoming increasingly looser. You decide to visit your dentist about this'. The first vignette corresponds with a relatively minor dental problem, most probably followed by non-invasive treatment. The second vignette corresponds with a more serious dental problem, which is likely to be followed by more invasive treatment.

In order to investigate whether patients' need for information and participation are related to patients' demographic variables and copingstyle, correlation coefficients were calculated and linear regression-analyses were performed. Differences in scores were determined by t-tests and Anova's. Reliability of the scales was determined by means of Cronbach's alpha and KR-20.

3 Results

3.1 Sample characteristics

The patient sample of survey one consisted of 96 patients, 52 men and 44 women, ranging in age from 17 to 77 years (mean=39.0). 119 Patients were asked to participate in the study, ten patients refused, and 13 patients initially agreed but failed to return the post-appointment questionnaire. 68 patients were visiting the dentist because of pain complaints, 28 patients were seeing the dentist for other dental problems, such as broken fillings, loose crowns and bridges, etceteras. 33.3% Of the patients completed higher vocational education or university, 35.5% of the patients completed intermediate vocational education, and 31.2% of the patients completed elementary school, lower vocational education or lower general secondary education.

The patient sample of survey two consisted of 245 patients, 116 men and 127 women, ranging in age from 18 to 78 years (mean=41.7). 25% Of the patients completed higher vocational education or university, 39% of the patients completed intermediate vocational education, higher general secondary education or pre-university education, and 36% of the patients completed elementary school, lower vocational education or lower general secondary education.

3.2 *Desire for information and participation*

Table 1 shows the reliabilities of the scales (KR-20 and Cronbach's alpha). With the exception of the API 'Decision-making preference' scale, the internal consistency of the various scales is satisfactory. Principal component analysis using varimax rotation confirmed the two-factor structure of the Deber-Kraetschmer PSDM scale in both surveys (problem-solving vs. decision-making) for both vignettes. For vignette one, 54.0% to 58.5% of the variance could be explained by these two factors, for vignette two, 56.4% to 62.7% of the variance was explained by the two factors.

Table 1 Reliability of the scales

	Survey one	Survey two
• HOS information subscale	KR 20=.61	KR 20=.65
• API information-seeking subscale	α =.73	α =.80
• API decision-making subscale	α =.57	α =.49
• Deber-Kraetschmer PSDM scale	α =.82	α =.74
• Deber-Kraetschmer PS subscale	α =.84	α =.81
• Deber-Kraetschmer DM subscale	α =.81	α =.82

The mean score on the HOS 'Information' subscale is respectively 3.8 (survey one; $sd=1.9$; range subscale 0-7) and 4.2 (survey two; $sd=1.9$; range subscale 0-7). Among patients from the first survey, 26.1% of the respondents has low scores (between 0-2), and hence, little desire to be informed and to ask questions, 35.4% has intermediate scores (between 3-4) and 38.5% of the respondents has high scores (5 and higher) on this scale. From the patients of the second survey, 16.8% of the respondents have low scores (between 0-2), 36.1% has intermediate scores (between 3-4) and 47.2% of the respondents has high scores (5 and higher).

Mean score on the API 'Information-seeking preference' subscale is 88.7 for survey one ($sd=8.6$) and 86.3 ($sd=9.9$) for survey two, where 0 indicates strong disagreement with statements favoring patients being informed, 50 indicates a neutral reaction, and 100 indicates strong agreement. Scores are skewed strongly to the right, indicating that most patients have a high preference for information. The API en HOS information subscales scores are not correlated and scores on the API subscale are significantly higher than those on the HOS subscale (scores on the HOS-scale were adjusted to API-scores) (paired samples t-test; $p<.001$).

Mean score on the API 'Decision-making preference' subscale is respectively 68.3 ($sd=14.2$) for the first survey and 61.5 ($sd=12.2$) for the second survey. Both scores are significantly lower than patients' scores on the 'Information-seeking

preference' subscale of the API (paired samples t-test; $p < .001$). Scores are distributed normally, indicating that patients' desire for participation in decision-making is more varied than their desire for information, as measured by the API 'Information-seeking preference' subscale.

Table 2 and table 3 give the mean scores on the PSDM scale for both surveys for each task and each vignette. A series of paired sample t-tests shows that all differences between the PS-scores and DM-scores are significant ($p < .001$), which confirms the expectation that patients do wish to hand over control with respect to problem-solving tasks to their dentist, but wish to be involved in decision-making tasks.

Table 2 Mean scores on PSDM scale in survey one

Vignette	Diagnosis	Treatment options	Risks/Benefits	Probabilities	Accepting risks/benefits	What is done
• minor dental problem	2.2	2.1	2.0	1.9	3.2	3.1
• serious dental problem	2.1	1.9	2.1	2.0	3.1	3.1

Table 3 Mean scores on PSDM scale in survey two

Vignette	Diagnosis	Treatment options	Risks/Benefits	Probabilities	Accepting risks/benefits	What is done
• minor dental problem	2.1	2.0	2.1	1.9	3.0	2.8
• serious dental problem	1.9	1.8	2.1	2.0	3.0	2.7

Frequencies of the scores on the PSDM scale, which are shown in Table 4 and table 5, also point out that patients desire to be involved in decision-making tasks.

Table 4 Distribution of PSDM scale scores in survey one on two vignettes together

Task	N	Hand over (score<3)	Share (score=3)	Retain (score>3)
Problem-solving				
• diagnosis	189	62.4%	36.5%	1.1%
• options	190	69.5%	28.9%	1.6%
• risks/benefits	190	69.5%	28.4%	2.1%
• probabilities	190	79.5%	19.5%	1.1%
Decision-making				
• accepting risks	190	23.7%	43.2%	33.2%
• what is done	190	15.3%	66.8%	17.9%

Table 5 Distribution of PSDM scale scores in survey two on two vignettes together

Task	N	Hand over (score<3)	Share (score=3)	Retain (score>3)
Problem-solving				
• diagnosis	485	73.4%	23.3%	3.3%
• options	483	78.1%	19.7%	2.3%
• risks/benefits	482	68.9%	27.0%	4.1%
• probabilities	478	78.7%	18.0%	3.3%
Decision-making				
• accepting risks	484	23.6%	51.4%	25.0%
• what is done	483	26.7%	66.0%	7.2%

Finally, a few differences in mean scores between the two vignettes were found: for both surveys, scores on the problem-solving task 'treatment options' are significantly higher for vignette one than for vignette two (paired samples t-test; respectively $p=.003$ and $p=.003$), and for survey one, mean score on the item 'diagnosis' is higher for vignette one than for vignette two ($p=.003$).

3.3 *Relations of patients' demographic variables and copingstyle to subscale scores*

Internal consistencies for the monitoring - as well as the blunting scale of the TMSI were satisfactory (range Cronbach's alpha respectively .78 to .87). Mean score on the monitoring scale is 37.2 (sd=8.0; range 12-60) for survey one and 34.5 (sd=9.0; range 12-60) for survey two. Mean score on the blunting scale is 35.4 (sd=8.4; range 12-60) for survey one and 34.8 (sd=7.7; range 12-60) for survey two.

Table 6 and table 7 show the results of the univariate analyses of patients' copingstyle, their age and education on each of the five subscale scores.

Table 6 Correlations of patient variables with desire for information and participation in survey one

	HOS	API- information	API- decision- making	Deber- Kraetschmer PS-scale	Deber- Kraetschmer DM-scale
• monitoring	0.21*	0.10	0.04	0.16	0.14
• blunting	-0.03	0.03	-0.19	0.13	-0.07
• age	0.17	0.12	0.24*	-0.07	-0.09
• education	0.35**(rho)	0.09 (rho)	0.21* (rho)	-0.11 (rho)	0.34**(rho)

* alpha <.05

** alpha <.01

Table 7 Correlations of patient variables with desire for information and participation in survey two

	HOS	API- information	API- decision- making	Deber- Kraetschmer PS-scale	Deber- Kraetschmer DM-scale
• monitoring	-0.25**	0.32**	0.12	0.21**	0.08
• blunting	0.09	-0.07	0.05	-0.01	-0.03
• age	0.02	0.03	-0.15*	-0.02	-0.09
• education	-0.24**(rho)	-0.08 (rho)	0.19* (rho)	0.05 (rho)	0.09 (rho)

* alpha <.05

** alpha <.01

As can be seen from the tables, results are not consistent across the two surveys. For example, for survey one more desire for information and participation is, in general, associated with higher education. However, the results for survey two with regard to the relationship of education with desire for information and

participation are much weaker. Even a significant negative correlation exists between patients' education and HOS score, meaning that the lower ones education, the higher the HOS score. Also, for survey one a positive significant correlation was found between a monitoring coping style and patients' desire for information as measured with the HOS scale. For survey two though, the correlation is negative. Generally, most correlations are weak and did not reach significance. No differences in scores on the five subscales were found as a function of the gender of the respondents.

Finally, stepwise regression analyses were performed to look for multivariate associations between patients' demographic variables and copingstyle and their desire for information and participation in medical decision-making. Results are given in table 8 and table 9 (next page). With regard to survey one, patients' education is the only variable explaining only a small amount of the variance in three of the five subscale scores. Apparently, patients with higher levels of education have higher needs for information and involvement in decision-making, a finding that is consistent with the results from other studies. For survey two, a monitoring copingstyle and higher education are negatively associated with patients' need for information as measured by the HOS. The other associations are in the expected direction, but explained variances are quite low for all dependent measures.

4 Discussion and conclusion

In this era of increased patient autonomy, surprisingly little attention has been given to dental patients' actual desire for information and involvement in decisions concerning their own care. Policymakers have introduced acts to protect the autonomy and rights of patients, without a complete understanding of what it is patients really want. The present study can be seen as an attempt to gain more insight into the preferences of different groups of dental patients with regard to being informed about their condition and being involved in decisions about dental care. Moreover, possible antecedents of these preferences were studied.

The results demonstrate clearly that regular as well as emergency dental patients have a high need for information, a finding consistent with the results from other studies among different samples of patients. However, in both surveys patients' scores on the HOS 'Information' subscale were substantially lower than their responses on the API 'Information-seeking preference' subscale. Both instruments are regularly used in research on patients' information preferences, but the validity of the HOS scale in assessing patients' desire for information is questionable.

Tables 8 & 9 Stepwise regression analysis of patients' demographic variables and copingstyle on their desire for information and participation

Table 8 survey one

Variable	R ²	B	p
HOS			
education	.09	.30	.005
API-information			
no variables entered	X	X	X
API-decision making			
education	.06	.24	.03
PS-scale			
no variables entered	X	X	X
DM-scale			
education	.16	.40	.000

Table 9 survey two

Variable	R ²	B	p
HOS			
monitoring	.07	-.23	.001
education	.11	-.22	.001
API-information			
monitoring	.09	.30	.000
API-decision making			
education	.04	.19	.004
PS-scale			
monitoring	.06	.26	.000
sex	.08	-.14	.04
DM-scale			
no variables entered	X	X	X

According to Nease & Blair Brooks (1995), the HOS does focus on past behaviors of the patient to obtain information (e.g. question-asking), and not so much on patients' desire for information. Moreover, three items of the HOS scale are strongly related to decision-making tasks. As Krantz, Baum and Wideman (1980) wrote: '... concerned with desire to ask questions and to be informed of and involved in medical decisions.' Hence, the HOS scale may actually measure patients' information-seeking behaviors instead of their desire for information. Thus, when solely interested in patients' preferences for information, future researchers better make use of the API scale than of the HOS scale, as is also suggested by Nease & Blair Brooks (1995).

The second question this study addressed was to what extent dental patients wish to be involved in decisions concerning their own care. At first glance, the answer to this question seems to be that patients are not that interested in being involved in medical decision-making, a finding consistent with the literature (e.g. Pruyn & van den Borne, 2001). It is clear indeed, that their preferences for involvement are lower than their wish to be informed. Thus, other factors and motives than their desire for involvement must underlie patients' information preferences. However, when distinguishing between problem-solving tasks and decision-making tasks as two different concepts of patient participation, as is suggested by Deber (1994), another picture emerges. Both surveys clearly demonstrate that patients do wish to be involved in decision-making tasks, though, in general, they do think that the dentist should be responsible for problem-solving tasks, such as diagnosing the case and identifying treatment options. One could say that this means that a true partnership between practitioner and patient integrates the expertise and knowledge of both parties (medical expertise vs. patient values) into the decision-making process. Only in that way genuine patient autonomy can be achieved.

For two reasons two different vignettes were used to assess patients' preferences for involvement in decision-making, one corresponding to a minor dental problem, the other one reflecting a more serious dental problem. First of all, several studies have shown that patients' desire for participation decreases with increasing severity of the condition (Deber, Kraetschmer & Irvine, 1996; Nease & Blair Brooks, 1995; Blanchard et al., 1988). Second, the Dutch Medical Treatment Contract Act, that established the principle of informed consent in 1995, makes a distinction between invasive and non-invasive treatments. Duties of health care practitioners concerning invasive treatments are stricter than their duties concerning non-invasive treatments. Specifically, they are required to obtain the patient's explicit consent to an invasive treatment, but may presuppose the patient's consent in the latter case. Results from both surveys, however, show that patients did not differ in their responses to the two vignettes. One possible

explanation is that their desire for involvement does not depend on the severity of the condition. This would, however, be in contrast with the findings from other studies. It is also possible that patients in this study were not aware of the difference in severity between the two vignettes, and hence, responded similar to both vignettes. Future studies should therefore make sure that differences in severity of condition are clear to the respondents. Besides, the legal distinction between invasive and non-invasive treatments may not be a real one in the perception of patients, so it would be wise to explicitly ask the patient's consent to every treatment.

Finally, results from both surveys show that most of the variance in the scores remains unexplained by patients' demographic variables and copingstyle. Moreover, results were not consistent between the two surveys. Unfortunately, other studies also failed to find strong associations between patients' characteristics and their need for information and participation in medical decision-making. Thus, the etiology question remains unanswered up till now. Possibly, situational factors such as previous health care experiences of patients and the diagnosis are at least as important in determining patients' preferences and should be taken into account in future studies. In the meantime, explicitly asking patients about their preferences for information and involvement in decision-making remains the best clinical approach, for a genuine informed consent can only be achieved when these preferences are made clear.

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