

Preferences for involvement in medical decision making: Comparing British and German views

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Abstract

Despite beneficial outcomes of patients' involvement in medical decision processes, it has been claimed that patients are generally not interested in medical decision making (MDM). Whereas current research focuses on actual MDM, this research explored the impact of nationality and perceptual processes examined. Preferences for involvement in decision making were tested MDM in a sample of 204 German and 143 British university students. Hierarchical multiple regressions were employed to explore the link between socio-demographic information, individuals' perceived relationship with their GP, Health Locus of Control–Powerful Others, perceptions regarding the frequency and sufficiency of information provision and involvement in MDM, and individuals' preferred level of involvement and information. A significant amount of the variance in individuals' preferences for involvement could be explained (Adjusted $R^2 = .59$, $p < .001$). Independent t -test analyses showed that British and German perceptions of care differed significantly on a variety of different measures. Separate analyses for the German and British group highlighted cross-national differences in care and preferences for involvement. The study suggests that preferences to become involved might depend more on perceptual processes than actual involvement in decision making, and that communication and national health policy could play an important role.

Keywords: *Medical decision-making, general practice, patient preferences, involvement*

Introduction

Patient involvement in medical decision making (MDM) is gaining more importance in medical practice as evidence shows that patients who actively participate in decisions about their medical care have more beneficial outcomes than patients who have no involvement (Brody, Miller, Lerman, Smith, & Caputo, 1989; Fallowfield, Hall, Maguire, Baum, & A'Hern, 1994; Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995; Street, Jr., & Voigt, 1997). Western health care as in the UK, for example, is shifting from a patient (from Latin *patiere*, to tolerate, or willing to bear) to a consumer (from Latin *to take up, to buy*)-based approach to medical services (Department of Health, 2001; Evans, Edwards, & Elwyn, 2003).

Regardless of the beneficial effects of collaboration in medical settings, some studies indicated that the increased responsibility deters patients from attempting to demand more involvement in MDM during consultations (Beisecker & Beisecker, 1990). Some have argued that diagnostic and treatment processes require too much medical knowledge and pharmacological expertise (Peters, 1994). However, more recent evidence suggests that these deductions might have been inadequate (Benbassat, Pilpel, & Tidhar, 1998; Robinson & Thomson, 2001). Results from a systematic review concluded that patients' preferences for involvement in MDM can vary from 22% to 81% (Baider, Ever-Hadani, & De Nour, 1995). Previous research suggests that a number of factors influence preferences for involvement in MDM as age (Rosén, Anell, & Hjortsberg, 2001; Rothenbacher, Lutz, & Porzolt, 1997), gender (Lerman et al., 1990; Pontes & Pontes, 1997) and education (Degner, Kristjanson, Bowman, & Sloan, 1997; Robinson & Thomson, 2001) consistently determined patients' interests for MDM. Other studies highlighted that patients' beliefs in the benefits of acquiring information and control of health professionals over one's health (Brashers, Haas, & Neidig, 1999), level of information (Ainslie & Beisecker, 1994), their expectations (Thompson & Sunol, 1995) and their GP's attitude towards involvement and general consultation style (Geller et al., 1998; Laine et al., 1996) are important influences.

In recent surveys about preferences for MDM, individuals are asked whether they prefer a collaborative, autonomic or directive approach (Ford, Schofield, & Hope, 2003; Sekimoto et al., 2004) —although preferences probably vary in different medical situations. Further research focussed on presenting individuals with video vignettes of a shared and a directive approach and assessed their preferred level of involvement in primary care decision making (McKinstry, 2000). Patients' preferences were influenced by the condition presented, age, social class and smoking status. Individuals rated their preferred style of involvement as similar to their own GP's style; however, the author did not provide a more detailed evaluation of their GP's approach. A systematic review highlighted the problems of adequate measurements for the process of "involving the patient" (Elwyn et al., 2001). Benbassat et al. (1998) found that as much as 80% of patients' preferences for involvement in decision making remained unexplained and suggested that the influence of communication should be further explored. This research tried to address some of these shortcomings by assessing preferences for involvement in primary care consultations and aspects such as information giving (e.g., about risks, future course, time allocation) and deciding between treatment options.

A paucity of studies focuses on whether national health policy has a significant effect on preferences for involvement in MDM (Coulter, 1997). This could be an important influence on preferences for involvement as different countries have different approaches to the physicians' role in medical care (Goldbart & Mukherjee, 1999; Sekimoto et al., 2004). For example a study that explored perceptions of the "ideal physician" in Russian and Israeli patients, found that 81% of Israeli patients stated that an ideal physician would share the decision-making with her/his patients, but only 14% of the Russian patients held this view (Baider et al., 1995). The current study investigated preferences for involvement in individuals, who had been subjected to two different countries. Britain and Germany were selected since they have a different approach to general practice and medical care provision. Even though GPs are at the forefront of containing costs in both countries, the role of German GPs seems slightly less focussed on funding issues as German patients had fewer restrictions to consult specialist health professionals independently and often switched between GPs and specialists at their leisure (Wahner-Roedler, Knuth, & Juchems, 1997). As this cross-national variation might be an important influence on preferences for

involvement, the current study assessed whether German and British patients' perceptions about their provision of care differed.

This study explored the effects of patients' socio-demographic characteristics, patients' relationship with their GP and patients' perceptions of how important doctors and other health professionals are in controlling their health on patients' preferences for involvement. Individuals' perceptions of primary care were determined and cross-national comparisons were conducted to test whether different health care systems affected individuals' perceptions.

Methods

Design

This study used a cross-sectional survey design.

Participants

The research aimed to explore the national differences in preferences about involvement in decision making. In order to make meaningful comparisons, it seemed important to ensure that a sample with similar socio-demographic characteristics was recruited and we therefore opted for student samples. In Britain, the data were collected at the University of London and at the University of Sussex. In Germany, the data were collected at the Heinrich Heine Universität in Düsseldorf. Potential participants were approached in lectures and/or in dining halls, cafeterias and so on, on university grounds, and asked whether they would like to take part in a study that investigated their relationship with their GP. Subjects who said that they did not have a GP or those who indicated that a member of their family was their GP were exempted. All other individuals who agreed to participate were given a questionnaire. The number of valid questionnaires was reduced after the sample was screened for the following exclusion criteria. Individuals who knew their GP for less than 1 year, who neither possessed British nor German nationality, or reported ratings about GPs from a separate health care system (not Britain/Germany) were excluded from the analysis. The criteria were chosen to control for confounding variables (e.g., short-term acquaintance with GP in comparison to long-term acquaintance) and to reduce the heterogeneity between the two groups. The final sample consisted of 143 British participants and 204 German participants.

Assessment instrument

The instrument assessed socio-demographic information (age, gender and nationality) and patients' perceptions of general practice care. Items regarding MDM were derived from the review of questionnaire assessments in the literature and via informal discussions with service users. The review highlighted the importance of two aspects associated with decision making—the desire for information provision and a comparison between the actual and preferred role in MDM (Brashers et al., 1999; Degner et al., 1997; Ende, Kazis, Ash, & Moskowitz, 1989; Nease & Brooks, 1995). The Autonomy Preference Index (Ende et al., 1989) assessed both of these aspects by framing them what the patient feels the physician should do whereas the Health Opinion Survey (Krantz, Baum, & Wideman, 1980) assesses preferences in terms of what the patient does to seek information. A study about preferences in breast cancer presented with five cards illustrating different roles of patients and physicians (Degner et al., 1997). Furthermore, several studies have examined decision

making at consultation level (Elwyn et al., 2003) and also related preferences to actual level of involvement (Ford et al., 2003). Additionally, a survey in which outpatient service users (Laine et al., 1996) ranked different characteristics of the service found that physicians' clinical skill, information provision and interpersonal skills were important for satisfaction and might thereby affect preferences. After a list of possible items for a questionnaire on general attitudes about decision making in GP consultations was compiled, these were informally presented to service users and items that were considered unsuitable, such as for example decisions about referrals or further diagnostic tests, were removed.

The English version of the questionnaire is presented in the Appendix.

The following variables were assessed with a 7-point Likert scale ranging from never (1) to always (7).

- a. *Patients' assessment of their relationship with their GP*: four items (e.g., "I can communicate well with my GP"; Cronbach's alpha = .83).
- b. *GP's provision of information and explanations during consultations*: six items (e.g., "My GP shares with me information about risks and side-effects associated with treatments"; Cronbach's alpha = .82).
- c. *Patient's involvement in MDM*: two selected primary care MDM' scenarios: (1) the amount of time spent on explanation and information and (2) decision making about different treatment options (Cronbach's alpha = .61).

In order to support the assessments based on frequency, two general questions were included. They measured whether participants felt that the amount of information/explanation and their involvement in decision making was sufficient.

- d. *Sufficiency of information and explanation giving and involvement in MDM*, for example, "Overall, do you feel that the amount of information and explanation you get from your GP is sufficient?: (Yes/No)".

Preferences for information or involvement was assessed with a 7-point Likert scale assessing whether they wanted more (7), the same (4) or less (1) information/involvement than they experienced in their current consultations.

- e. *Preferences for information and explanations during primary care consultations*: six items see under (b) (Cronbach's alpha = .88).
- f. *Preferences for involvement in MDM during primary care consultations*: two scenarios see under (c) (Cronbach's alpha = .84).

To assess the importance of personality or individual differences, we included another Likert scale that measures beliefs of how much control powerful others might have over individuals' status of health from strongly disagree (1) to strongly agree (6).

- g. *Individual differences*: the scale was selected from the Multidimensional Health Locus of Control Scale *MHLC* Form A (Wallston, Wallston, & DeVellis, 1978). The subscale Powerful Others Locus of Control contains six items (e.g., Health professionals control my health; Cronbach's alpha *PHLC* = .64).
- h. *Demographic variables*: participants' nationality, age, gender.

The instrument was translated into German by the first author and independently back-translated by colleagues from the University of Düsseldorf. Difficult items and terminology were discussed until a consensus was reached.

Statistical analysis

All of the data were entered onto SPSS for Windows (Version 10.0). Items of the scales were collapsed and mean scores for the separate scales were computed; this was done in accord with high correlation of the scales items and the scales' acceptable internal consistency (Cronbach' alpha .61 – .86). Perceptions of health care in two different health care systems were compared using independent *t*-tests. A hierarchical multiple regression was used to analyse the influence of selected variables for the preferences for involvement in decision making.

Results

The mean age of participants' of the whole sample ($N = 347$) was 25.44 years ($SD = 6.55$; range 18–60). In the British group ($n = 143$) the mean age was 23.22 ($SD = 6.86$) and in the German ($n = 204$) group 26.99 ($SD = 5.87$). In the whole sample, 31.1% were male and 68.9% female. For the British group 29.4% were male and 70.6% female, and in the German group 32.4% were male and 67.6% female. We also found variations in terms of frequency of GP visits. The British sample 32.9% visited their GP less than once a year, 62.2% visited their GP once a year or more (1–11 times) and 4.9% visited their GP once a month or more (≥ 12 times a year). To contextualize, the general population in the UK in that age range (16–44 years) visit their GP 4 times a year (Office for National Statistics, 2003). In the German group, 20.1% visited their GP less than once a year, 73% visited their GP once a year or more (1–11 times) and 6.9% visited their GP once a month or more (≥ 12 times a year).

Table I shows patients ratings of the sufficiency of the information provision and involvement in decision making in general practice consultations. The majority of patients (between 64% and 79%) thought that their current level of information and current involvement was sufficient.

Table II illustrates patients' mean ratings on the scales and the results of independent *t*-tests comparing patients' perceptions of their health care. German and British individuals differed significantly in ratings of GP–patient communication, GP information and explanation and involvement in decision making. British participants scored significantly lower, which means that they rated good communication with their GP, adequate information and involvement in MDM as less frequent than their German counterparts. Furthermore, British participants also significantly differed in their preferred level of

Table I. Ratings of the sufficiency of information and involvement in the whole sample ($N = 347$) and according to nationality—British ($n = 143$) or German ($n = 204$).

Characteristics	Complete sample	British	German
<i>Sufficient information</i>			
Yes (%)	257 (74.3%)	95 (66.9%)	162 (79.4%)
No (%)	89 (25.7%)	47 (33.1%)	42 (20.6%)
<i>Sufficient involvement</i>			
Yes (%)	244 (72.2%)	89 (64.0%)	155 (77.9%)
No (%)	94 (27.8%)	50 (36.0%)	44 (22.1%)

involvement in MDM, indicating that they wanted significantly more involvement in MDM than the German patients. The groups did not, however, differ in terms of their preferences for information/explanation, or their belief in the control of powerful others over their health.

Hierarchical multiple regression analyses for the complete sample are displayed in Table III and separately by nationality in Tables IV and V. The selected variables explained a

Table II. Means and SDs for the different scales of the questionnaire and independent samples *t*-tests comparing British (*n* = 143) ratings with German (*n* = 204) ratings.

	<i>M</i> (<i>SD</i>)	<i>t</i> (<i>df</i>)	95% <i>CI</i>	<i>p</i> -value
<i>Patients' ratings for GP-patient communication</i>				
British	4.32 (1.33)	-8.34 (345)	-1.34 to -.83	< .001
German	5.41 (1.09)			
<i>Patients' ratings of GP's information/explanation</i>				
British	4.52 (1.16)	-5.16 (345)	-.90 to -.40	< .001
German	5.17 (1.15)			
<i>Patients' ratings of their involvement in MDM</i>				
British	3.70 (1.36)	-4.38 (341)	-.98 to -.38	< .001
German	4.38 (1.46)			
<i>Patients' preferences for information/explanation</i>				
British	4.85 (0.94)	.657 (345)	-.14 to .28	.512
German	4.78 (0.97)			
<i>Patients' preferences for involvement in MDM</i>				
British	5.06 (1.06)	3.12 (340)	.13-.56	.002
German	4.71 (0.97)			
<i>Patients' PHLC score</i>				
British	14.59 (4.59)	.529 (316)	-.73 to 1.26	.597
German	14.39 (4.27)			

MDM, medical decision making.

Table III. Hierarchical multiple regression analyses predicting preferences for involvement in medical decision making (MDM, *n* = 347).

	Adjusted <i>R</i> ² for whole sample	Variables	Beta weights
Demographic variables	.033 (<i>p</i> < .004)	Nationality	-.065 (<i>p</i> = .119)
		Age	.038 (<i>p</i> = .358)
		Gender	.060 (<i>p</i> = .105)
GP patient communication	.222 (<i>p</i> < .001)	GP-patient communication	-.111 (<i>p</i> = .037)
Personality variables	.220 (<i>p</i> < .001)	Powerful others locus of control	.038 (<i>p</i> = .313)
		GP's information and explanation	.039 (<i>p</i> = .497)
Patients' perception of actual information and explanation	.389 (<i>p</i> < .001)	Sufficiency of current information	.120 (<i>p</i> = .020)
Patients' perception of actual involvement in MDM	.442 (<i>p</i> < .001)	Involvement in MDM	-.077 (<i>p</i> = .151)
		Sufficiency of current patient involvement MDM	.153 (<i>p</i> = .002)
Patient's preferences for information	.593 (<i>p</i> < .001)	Preferences for information and explanation	.509 (<i>p</i> < .001)

Table IV. Hierarchical multiple regression analysis predicting preferences for involvement in the British group ($n = 143$).

	Adjusted R^2 for British group	Variables	Beta weights
Demographic variables	.014 ($p < .204$)	Age	.065 ($p = .317$)
		Gender	.071 ($p = .253$)
GP patient communication	.199 ($p < .001$)	GP-patient communication	-.076 ($p = .375$)
Personality variables	.192 ($p < .001$)	Powerful others locus of control	.052 ($p = .411$)
Patients' perception of actual information and explanation	.362 ($p < .001$)	GP's information and explanation	.038 ($p = .399$)
		Sufficiency of current information	.160 ($p = .049$)
Patients' perception of actual involvement in MDM	.452 ($p < .001$)	Involvement in MDM	-.095 ($p = .252$)
		Sufficiency of current patient involvement MDM	.168 ($p = .030$)
Patient's preferences for information	.576 ($p < .001$)	Preferences for information and explanation	.483 ($p < .001$)

MDM, medical decision making.

Table V. Hierarchical multiple regression analysis predicting preferences for involvement in the German group ($n = 204$).

	Adjusted R^2 for German group	Variables	Beta Weights
Demographic variables	-.006 ($p < .827$)	Age	.014 ($p = .790$)
		Gender	.056 ($p = .255$)
GP patient communication	.192 ($p < .001$)	GP-patient communication	-.119 ($p = .061$)
Personality variables	.188 ($p < .001$)	Powerful others locus of control	.034 ($p = .492$)
Patients' perception of actual information and explanation	.355 ($p < .001$)	GP's information and explanation	.041 ($p = .575$)
		Sufficiency of current information	.089 ($p = .214$)
Patients' perception of actual involvement in MDM	.383 ($p < .001$)	Involvement in MDM	-.069 ($p = .341$)
		Sufficiency of current patient involvement MDM	.142 ($p = .047$)
Patient's preferences for information	.563 ($p < .001$)	Preferences for information and explanation	.541 ($p < .001$)

MDM, medical decision making.

large proportion 59% of preferences for greater involvement in decision making. When analyses were separated by nationality, the effects are similar, as 58% are explained in the British group and 56% is accounted for in the German group.

Significant individual predictor variables included those where people indicated whether GP's information/explanation and patients' involvement in MDM was sufficient or not, and their assessment of their GP relationship and preferences for information. Despite the higher number of similarities between German and British participants, some cross-national differences could be observed in the analyses by nationality. Whereas for the British group the sufficiency of information provided in their consultation was an important predictor for their preferences for decision making, this was not significantly predictive of preferences in the German group.

Discussion

Summary of the findings

The selection of explanatory variables predicted more than half of the variance (59%) in individuals' preferences for decision making. Neither demographic nor personality variables added significantly to the regression. GP related variables and perceptions of general practice care explained most of individuals' preferences for involvement in general practice MDM.

Individuals from both groups perceived the amount health professionals control have over individuals' health similarly and also did not differ in their preferences for information and explanation. However, British participants rated their GP's ability to communicate effectively, adequately explain and involve them in MDM significantly less frequent than German individuals. In addition, British individuals preferred significantly more involvement than their German counterparts.

Preferences for information and patients' perception of the sufficiency of their current involvement emerged as the strongest individual predictor variable in all three analyses. Ratings of how often individuals were actually involved in MDM and how often they were actually informed did not emerge as a significant predictor. These findings suggest that patients' preferences are linked in with subjective perceptual processes regarding their health care, but that individuals' objective level of involvement or information provision frequency might not be as important. As decision-making research trends stress the importance of more objective measurements of involvement (Elwyn et al., 2003), this research highlights the necessity of subjective assessments as well. The results show that GP's actual involvement of their patient and information provision might not be as important, but that subjective evaluation is one of the key elements determining the desire for involvement.

Patients' assessment of whether the amount of information provided by their GP was sufficient for them attained significance in the analysis for the complete sample and the British group, but was not significant in the German analysis. In this group, individuals' assessment of their GP-patient communication almost achieved significance, which appears to be an important national difference.

Contradicting earlier evidence

Overall, individuals in our sample wanted *more* involvement in decision making, challenging evidence that claimed that patients' have no interest in involvement. This might be due to examining preferences for involvement in decision-making tasks that individuals felt comfortable with. Furthermore, demographic factors had little to no importance in predicting preferences for participation in decision making. We should firstly acknowledge here that our sample was not representative of a general population sample, as it focussed on unravelling the influence of nationality and perceptual determinants of the desire for decision making. One must contend that it appears likely that a general population sample would exhibit more variation and hence one would expect a greater influence of demographic factors such as age, gender and education. However, it could also be that the predictor variables that we included, such as patients' perception of their relationship with their GP and an assessment of sufficiency of information and involvement, could be more predictive for patients' preferences for involvement than either demographic information or individual differences. Further research is needed to explore these possibilities in greater detail.

In contrast to Benbassat et al. (1998), who found that as much as 80% of the variance remained unexplained, the majority of the variance could be explained in this study. Future

research of patients' preferences for participation in decision making might therefore benefit from routinely including patients' assessments of doctor–patient communication and patients' appraisal of their care as possible predictive determinants.

Additional observations

The instrument was found to possess good internal reliability and face and content validity. Construct validity of the assessment can be demonstrated by linking it with a study on the preferred level of involvement in actual general practice consultations (Ford et al., 2003). Whereas Ford et al.'s study examined post-consultation results, our study attempted to assess more generalized perceptions across consultations with their GP. Assessing actual involvement and preferential involvement did confirm the conceptual difference between the two measures and the importance as highlighted by Degner et al. (1997). The difference between information seeking and decision making inherent in the Autonomy Preference Index (Ende et al., 1989) was also supported by our data. One might therefore be able to infer some construct validity for our measure, although of course other studies with concurrent measures are necessary to examine this more clearly.

Patients' preferences for involvement appeared to be in part dependent on some level of dissatisfaction with health care, as the British group, who felt that their relationship was not as good, preferred more involvement than the German group. Whether the care provided is actually different between the two countries was, however, not assessed and needs to be explored in further studies. Whereas other studies investigating preferences for involvement mainly concentrated on individuals who are terminally or severely ill, this could explain why preference for involvement was much higher in our sample. Young, educated and healthy individuals might have fewer inhibitions to state their preferences in an anonymous survey, but could be just as reluctant to have and express desires for involvement in MDM during consultations when ill.

Although the research sample is small and maybe not representative of the general population, the results suggest that the national culture and characteristics of health services do influence preferences for involvement in decision making and also evaluation of care. It may be that British GPs' greater level of constraints and dissatisfaction with their job role (Evans, Lambert, & Goldacre, 2002; Warwicker, 1998) does transfer to the patient. It could also be that there are different types of health care taught in different countries and or that other cultural aspects play an important role in the assessment of preferences. Also it is important to replicate the findings in an older sample who may visit their GP more often. Since the current data does not allow us to reject any ideas unequivocally, more detailed cross-national comparisons of care provision and their effects on service users' experience of care should be conducted to reject the hypotheses with greater certainty. To determine whether actual health care differs between Germany and the UK, it seems important that future studies relate subjective assessments with more objective observational data from general practice consultations. Knowing more about the link between perceptions of care and actual care could help to ensure that the best service will be made available to the patient.

Conclusion

The creation of a more patient-centred health care has been shown to lead to better outcome for patients (Brody et al., 1989; Coulter, 1997; Fallowfield et al., 1994). Its implementation is largely dependent on patients' preferences to engage and become involved in MDM

processes. In order to determine preferences for involvement, our research suggests that health professionals and policy makers need to focus on patients' perceptions of care. Patients' assessment of the GP–patient communication added most to the explanation of the variance in patients' preferences for involvement, indicating that GP's ability to communicate is the key determinant to increase patients' preferences for involvement.

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Involvement in medical decisions

This questionnaire was designed to investigate personal attitudes about medical decision making; the data will be used solely for research purposes and will remain strictly confidential.

Demographic factors

- 1) Gender: M/F
 - 2) Age: _____
 - 3) Nationality: _____
 - 4) Country of Birth: _____
 - 5) If your country of birth is **not** British, how long have you been resident in Britain?
-

6) Ethnicity:

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| White | Black Caribbean | Black African | Indian |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pakistani | Bangladeshi | Chinese | Other |

7) Father's occupation: _____

8) Mother's occupation: _____

Contextual information

9) I have been with the same GP for _____ years/months (Delete as appropriate)

10) Approximately how often do you consult your GP:

- | | |
|----------------------------|--------------------------|
| Once or more times a month | <input type="checkbox"/> |
| Once or more times a year | <input type="checkbox"/> |
| Less than once a year | <input type="checkbox"/> |

Relationship with GP

11) My GP and myself share a trusting and supportive relationship:

Always ----- Never
1 2 3 4 5 6 7

12) I feel that I can **not** talk with my GP about non-medical problems

Always ----- Never
1 2 3 4 5 6 7

13) The quality of my relationship with my GP is very good

Always ----- Never
1 2 3 4 5 6 7

14) I am **not** satisfied about my relationship with my GP

Always ----- Never
1 2 3 4 5 6 7

Perceived expertise

15) I believe that my GP is **not** proficient in medical terms

Always ----- Never
1 2 3 4 5 6 7

16) In my opinion my GP is a medical expert

Always ----- Never
1 2 3 4 5 6 7

17) My GP's behaviour during my consultations illustrates that my GP has **little** medical skill

Always ----- Never
1 2 3 4 5 6 7

18) I reckon that my GP's knowledge about symptoms, diseases and treatments is very good

Always ----- Never
1 2 3 4 5 6 7

Reality of information/explanation giving in general practice

The following statements are concerned with selected aspects of what happens **in your consultations with your GP**, please rate them with regards to what most applies to **you**. Please answer **all** items **carefully**, but do not spend much time on any one item.

19) My GP allows sufficient time for information and explanation giving:

Always ----- Never
1 2 3 4 5 6 7

20) My GP explains my illness to me:

Never ----- Always
1 2 3 4 5 6 7

21) My GP explains my treatment to me:

Always ----- Never
1 2 3 4 5 6 7

22) My GP describes different treatment options to me:

Never ----- Always
1 2 3 4 5 6 7

23) My GP shares with me information about the risks and side-effects associated with treatments:

Always ----- Never
1 2 3 4 5 6 7

24) My GP explains the likely course of a treatment:

Never ----- Always
1 2 3 4 5 6 7

Preferences for information/explanation giving in general practice

In this section you are asked to determine whether the amount of information/explanation you get from your GP is sufficient for you. Therefore indicate here if you want the **same**, **more** or **less** amount of information/explanation about the medical process.

25) I would prefer that my GP allocated

less ----- same ----- more
 1 2 3 4 5 6 7

time for information and explanation.

26) I would prefer that my GP explained my illness

less ----- same ----- more
 1 2 3 4 5 6 7

27) I would prefer that my GP explained my treatment

more ----- same ----- less
 1 2 3 4 5 6 7

28) I would prefer that my GP described different treatment options:

less ----- same ----- more
 1 2 3 4 5 6 7

29) I would prefer that my GP shared with me information about risks and side-effects associated with treatments:

more ----- same ----- less
 1 2 3 4 5 6 7

30) I would prefer that my GP explained the likely course of a treatment:

less ----- same ----- more
1 2 3 4 5 6 7

Reasons for

Overall, do you feel that the amount of explanation and information that you get from your GP is sufficient?

Yes No

If the answer to the previous question was **no**, could you please write down three most important reasons that make you feel that way

① _____
② _____
③ _____

If the answer to the previous question was **yes**, could you also please write down your most important three reasons that make you feel that way

① _____
② _____
③ _____

Reality of involvement in decision making in general practice

This section will look at how much you get involved in medical procedures by your GP. Could you please rate them with regards to what most applies to **you**. Again, please answer **all** items **carefully**, but do not spend much time on any one item.

31) My GP allows me to determine the amount of time allocated for information and explanation giving:

Always ----- Never
1 2 3 4 5 6 7

32) My GP involves me in the decision about how much information/explanation I will get about my illness:

Never ----- Always
1 2 3 4 5 6 7

33) My GP involves me in the decision about how much information/explanation I will get about my treatment:

Always ----- Never
1 2 3 4 5 6 7

34) My GP lets me decide between different treatment options:

Never ----- Always
1 2 3 4 5 6 7

35) My GP lets me determine the amount of information I will get about risks and side-effects associated with treatments:

Always ----- Never
1 2 3 4 5 6 7

36) My GP lets me determine the amount of information/explanation I will get about the likely course of a treatment:

Never ----- Always
1 2 3 4 5 6 7

Preferences for involvement in decision making in general practice

In this section you are asked to determine whether the amount of involvement you get from your GP is sufficient for you. Therefore indicate here if you want the **same**, **more** or **less** involvement in the medical process.

37) In the decision about how much time during a consultation will be allocated for information and explanation giving, I would like

less ----- same ----- more
1 2 3 4 5 6 7

involvement.

38) In the decision about how much information/explanation I will get about my illness, I would like:

less ----- same ----- more
1 2 3 4 5 6 7

involvement.

39) In the decision about how much information/explanation I will get about my treatment, I would like:

less ----- same ----- more
1 2 3 4 5 6 7

involvement.

40) In the decision about different treatment options, I would like:

less ----- same ----- more
1 2 3 4 5 6 7

involvement.

41) In the decision about the amount of information I will get about risks and side-effects associated with treatments, I would like:

less ----- same ----- more
1 2 3 4 5 6 7

involvement.

42) In the decision about the amount of information/explanation I will get about the likely course of a treatment, I would like:

less ----- same ----- more
1 2 3 4 5 6 7

involvement.

Reasons for involvement in decision making

Overall, do you feel that your involvement in decision making is sufficient?

Yes No

a) If the answer to the previous question was **no**, could you please write down your **three** most important reasons that make you feel that way

① _____
② _____
③ _____

b) If the answer to the previous question was **yes**, could you also please write down your **three** most important reasons that make you feel that way

① _____
② _____
③ _____

Thank you very much for your participation!