Decision analysis for newly diagnosed hypertensive patients: a qualitative investigation

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Abstract
This study adopted a qualitative approach to explore patients’ views on the usefulness of a decision analytic decision aid (DA). Semi-structured interviews were conducted with 15 newly diagnosed hypertensive patients who had been recruited for a factorial randomised controlled trial of two decision aids. Issues investigated included respondents’ attitudes to information, their views on the nature of their relationship with their general practitioner (GP) (paternalistic, shared or consumerist), the ease of use and potential wider application of the computerised decision aid and its influence upon their decision-making about whether or not to begin anti-hypertensive treatment. Views on the decision aid were favourable. For the majority, the decision aid appeared to confirm and/or clarify their stated preferences towards medicine-taking. Occasionally it could provoke a major shift in a respondent’s attitude to medicine-taking, while in a few it had no discernible effect. While views on the decision aid were favourable, it was difficult to determine whether this was due to the individualised cardiovascular risk information it provided or the decision analytic process itself.

Keywords: Qualitative research; Decision aids; Decision analysis; Patient information; Hypertension

1. Introduction

Decision aids (DA) are tools to facilitate patient involvement [1] in decisions about their health care and can be seen as one way of operationalising the principles of informed shared decision-making [2]. This shared model of treatment decision-making promotes active patient involvement in the decision-making process [3] and can be seen as an approach distinct from the traditional paternalistic model of doctor–patient interactions. The goals of decision aids vary; they can clarify patients’ goals or may communicate risk, improve patient knowledge or facilitate various behavioural outcomes such as compliance with treatment [4]. A systematic review revealed that decision aids increase knowledge, lower the uncertainty surrounding the decision-making process and allow more active patient participation in decision-making [1]. Decision aids have been developed in many therapeutic areas including atrial fibrillation [5], hormone replacement therapy [6] and benign prostatic hyperplasia [7].

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When assessing the effectiveness of decision aids, the traditional approach has been to use a variety of quantitative outcome measures such as patient uncertainty surrounding decision-making (the Decisional Conflict Scale), patient knowledge, anxiety, compliance with treatment, functional status, symptom resolution or satisfaction [8–12]. A qualitative approach can complement such quantitative outcomes by enabling a broader perspective on how patients view a decision aid. Few studies have, however, adopted a combined qualitative and quantitative approach [13]. In a recent randomised controlled trial we investigated whether a decision analytic decision aid was associated with changes in decisional conflict, knowledge, anxiety, treatment intentions and actual treatment choice in newly diagnosed hypertensive patients [14]. This study found that patients who received the decision aid had lower decisional conflict, greater knowledge about hypertension and no increase in state anxiety than those who did not receive the decision aid. The present qualitative study builds upon the quantitative findings to explore patients’ perceptions of the decision aid, to include the role of information in guiding patient decision-making, their views on the decision aid’s use and potential wider application in general practice and its impact upon their decision-making on whether or not to take tablets.
2. Methods

Fifteen follow-up interviews were conducted with participants from the main trial [14]. To be eligible for the trial, patients had to be between 30 and 80 years old, not currently taking anti-hypertensive medication and to have had a sustained raised blood pressure at a level where their general practitioner (GP) was considering initiating pharmacological treatment. The presence of cardiovascular disease was not an explicit exclusion criteria. Two interventions were investigated: a computerised decision analysis decision aid and an information video with leaflet. The stages of the decision analysis decision aid were:

1. Patients’ utilities, or preferences, for eight outcome health states that may result from the treatment or non-treatment of hypertension (Table 1) were elicited using the standard gamble [15–17].
2. Individual cardiovascular risk was calculated using clinical data and a Framingham risk equation [18].
3. Utilities and risks were combined in a decision tree using decision analysis software.

There were 217 participants in the main trial, with 51 receiving the decision analysis decision aid plus video/leaflet and 52 receiving the decision analysis decision aid alone [14]. Recruitment for the follow-up interviews took place in the last 3 months of trial recruitment.

2.1. The decision analysis decision aid

Stage (1) was a self-administered computerised interview designed for patients to complete unaided. In the factorial design, participants were randomly allocated to one of four groups: neither intervention, decision analysis only, video/leaflet only or both interventions. AM gave an initial explanation of the decision aid and was present in the room while the patient completed the programme. He answered questions related to the use of the computerised decision analysis but did not provide additional clinical information on blood pressure or its treatment. For stage (1) the standard gamble method requires the patient to make a hypothetical choice between the certainty of a lifetime in the intermediate health state of interest (such as those shown in Table 1) and a gamble, with the outcomes of perfect health and death (for example, a 70% chance of perfect health, 30% chance of death). The probability, \( p \), of perfect health is varied until the patient is unable to choose between the intermediate health state and the gamble, at which point \( p \) provides the utility value for the health state in question. Fig. 1 shows how the standard gamble was used in this particular context.

Decision analysis is a normative decision-modelling tool, representing rational decision-making taking account of probabilities of events and how a person feels about those events. Stages (2) and (3) were performed and explained by AM. The outcome of the decision analysis is an ‘optimum’ decision, based on the maximum expected utility value, about whether to accept or decline pharmacological therapy.

At the end of the computer-aided consultation, participants were given a printed sheet with their cardiovascular risk and the outcome of the decision analysis. One of the secondary outcomes measured in the trial was patients’ intentions about starting treatment (yes, no or unsure). This was measured before and after receiving the computerised decision aid.

2.2. Data collection and analysis

All 22 patients allocated to receive the decision analysis intervention (with or without the information video and leaflet) during the final 3 months of the trial recruitment period were asked to participate in the follow-up interviews at the end of the decision analysis consultation. Of these, five were going on holiday for a fortnight, one refused, one cancelled and did not rearrange and 15 (68%) were interviewed. These interviews sought the respondent’s attitudes to information—how much and from where, their views on the nature of their relationship with their GP (paternalistic, shared or consumerist), how easy/difficult they found the computer programme to use, its potential wider application and the factors influencing their decision to take anti-hypertensive treatment. At the time of recruitment, respondents were informed that the interviewer conducting

### Table 1

<table>
<thead>
<tr>
<th>Scenario (intermediate health state)</th>
<th>Taking anti-hypertensive tablets</th>
<th>Side effects from tablets</th>
<th>Cardiovascular event (CVE)</th>
<th>Affected by CVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>–</td>
<td>–</td>
<td>0.9995 (0.6–0.9995)</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>Yes</td>
<td>–</td>
<td>0.91 (0.5995–0.9995)</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td>–</td>
<td>Yes</td>
<td>0.91 (0.5995–0.9995)</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>0.97 (0.62–0.9995)</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>0.93 (0.75–0.9995)</td>
</tr>
<tr>
<td>6</td>
<td>Yes</td>
<td>–</td>
<td>Yes</td>
<td>0.5 (0.0005–0.99)</td>
</tr>
<tr>
<td>7</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>0.5 (0.0005–0.99)</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>0.5 (0.0005–0.99)</td>
</tr>
</tbody>
</table>

*These are the medians and ranges for the sample of 15 in the qualitative study. The values from the main trial [14] were very similar.*
The patient is asked to consider the following health state (corresponds to health state four, Table 1):

The patient is asked to choose between two options:

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The ‘Sure Thing’</strong></td>
<td><strong>The ‘Gamble’</strong></td>
</tr>
<tr>
<td>• Taking anti-hypertensive tablets</td>
<td>• 50% chance of perfect health</td>
</tr>
<tr>
<td>• Not experiencing any side effects from the tablets</td>
<td>• 50% chance of immediate painless death</td>
</tr>
<tr>
<td>• Experiencing a cardiovascular event</td>
<td></td>
</tr>
<tr>
<td>• Not affected by the cardiovascular event</td>
<td></td>
</tr>
</tbody>
</table>

If the patient chooses Option 1, then the display will change to show an increase in the probability of perfect health. The probability of perfect health will keep increasing as the patient continues to choose Option 1. If the patient then changes his/her mind and chooses Option 2 (i.e. prefers the ‘gamble’ to living the remainder of their life in the health state described in Option 1), then the probability of death increases.

This iterative process continues until the point of indifference, when the patient cannot decide between the ‘sure thing’ and taking the ‘gamble’. At the point of indifference, the probability of perfect health in the ‘gamble’ is equal to the utility value for the health state (number 4) in question.

Fig. 1. The standard gamble.

the follow-up interviews (MW) was not associated with the main trial and that ‘true opinion’ of the computerised decision aid was being sought.

The interviews lasted approximately 40 min (range 20-65 min) and most were conducted within 5 days after the decision aid was administered (range 2 h to 2 weeks). Respondents (Table 2) were shown the decision aid again during the course of the interview to help stimulate discussion. The researcher present when the decision aid was administered (AM) was not present when the interviewer (MW) discussed the decision aid with the respondent, nor was AM aware of the views of particular respondents. The interview tapes were transcribed and the transcripts analysed using the framework method of analysis. Key issues and themes in relation to the main objectives of the study were identified and grouped into subject headings by MW. This process was iterative such that subject headings and the categorisation of the data were further refined upon.

Table 2
Characteristics of interview respondents: preferences for taking tablets pre- and post-completing decision aid (DA)

<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Sex</th>
<th>Absolute cardiovascular risk over 5 years (Framingham risk equation) (%)</th>
<th>Preference for taking tablets pre-DA</th>
<th>Decision indicated by DA</th>
<th>Preference for taking tablets post-DA</th>
<th>Tablets prescribed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>60</td>
<td>F</td>
<td>6.9</td>
<td>TT</td>
<td>TT</td>
<td>TT</td>
<td>Y [BP down]</td>
</tr>
<tr>
<td>2</td>
<td>62</td>
<td>F</td>
<td>17.6</td>
<td>U</td>
<td>NTT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>62</td>
<td>F</td>
<td>10.8</td>
<td>TT</td>
<td>TT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>67</td>
<td>M</td>
<td>22.6</td>
<td>TT</td>
<td>NTT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>58</td>
<td>M</td>
<td>10.6</td>
<td>TT</td>
<td>NTT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>6</td>
<td>47</td>
<td>M</td>
<td>5.5</td>
<td>TT</td>
<td>TT</td>
<td>U</td>
<td>N [lifestyle changes]</td>
</tr>
<tr>
<td>7</td>
<td>64</td>
<td>F</td>
<td>10.1</td>
<td>NTT</td>
<td>NTT</td>
<td>U</td>
<td>N [lifestyle changes]</td>
</tr>
<tr>
<td>8</td>
<td>51</td>
<td>M</td>
<td>3.2</td>
<td>U</td>
<td>NTT</td>
<td>U</td>
<td>Y</td>
</tr>
<tr>
<td>9</td>
<td>60</td>
<td>M</td>
<td>14.2</td>
<td>TT</td>
<td>TT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>10</td>
<td>65</td>
<td>M</td>
<td>16.4</td>
<td>TT</td>
<td>TT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>11</td>
<td>53</td>
<td>F</td>
<td>5.3</td>
<td>U</td>
<td>NTT</td>
<td>U</td>
<td>Y [patient not taking them]</td>
</tr>
<tr>
<td>12</td>
<td>69</td>
<td>M</td>
<td>30.7</td>
<td>U</td>
<td>TT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>13</td>
<td>65</td>
<td>F</td>
<td>8.3</td>
<td>U</td>
<td>NTT</td>
<td>TT</td>
<td>Y</td>
</tr>
<tr>
<td>14</td>
<td>72</td>
<td>F</td>
<td>24.6</td>
<td>U</td>
<td>NTT</td>
<td>TT</td>
<td>N [BP down]</td>
</tr>
<tr>
<td>15</td>
<td>50</td>
<td>M</td>
<td>8.6</td>
<td>NTT</td>
<td>NTT</td>
<td>NTT</td>
<td>N</td>
</tr>
</tbody>
</table>

Key—TT: take tablets; NTT: not take tablets; U: unsure.
re-reading of the data. The key themes and issues emerging from the data are presented.

3. Results

3.1. Attitudes to information

One of the aims of the interviews was to explore how respondents viewed their relationship with their general practitioner and whether they wanted a shared, as opposed to paternalistic, decision-making style in their doctor-patient interactions. This issue was approached by asking respondents whether they liked to sit and discuss issues with their doctor or whether they preferred to be told what to do. A few respondents felt they were able to discuss issues with their doctor, but most either said that they just ‘did as they were told’ or that they tried to discuss things but felt the GP did not have enough time:

“I do prefer to sit and discuss things. But they have very little time and I’m not being critical, but they have very little time. Um, so that sometimes is a bit difficult.” [Respondent 7]

Most were interested in acquiring more information. They described a number of sources they would use to try to find out more information such as friends, leaflets, the library, magazines, medical reference books and the internet:

“I talked to friends, as I said, I had a couple who have recently gone down this path . . . we referred to our, sort of, book at home and we read up, really to find out what type of pills there are and the side effects and so forth.” [Respondent 9]

[I: Surfing the Net, would you be likely to go on it now and look at things about high blood pressure tablets?] “Oh yes, yeah.” [I: You would. Have you done so yet?] “Yes.” [Respondent 11]

Interestingly, respondents viewed discussing their condition (or not) with their GP and finding out more about treatment as two quite unrelated processes. Few saw finding out more information as informing their conversations with their GP and no respondent mentioned their GP as a source of additional clinical information:

“I don’t necessarily discuss it with the GP. I’d think about it though. I’d go home and think about it.” [I: Right, and then would you go back to the GP if you had any questions or anything?]. “Um, I doubt it actually. I’d probably work it out in my own mind. Ask other people, people that I knew were taking tablets.” [Respondent 2]

Clearly the relationship between respondents’ views on their relationship with their GP and whether or not they sought additional information was complex. Several respondents favoured a paternalistic relationship with their doctor (‘just doing what the doctor said’), yet would also actively seek out additional information on their condition (informed or consumerist approach). Others, when discussing their relationship with their doctor more generally, were more reticent about doing what the doctor recommended until they had obtained and considered further clinical information for themselves. In this sense, the decision aid was viewed as a useful source of information. Respondents saw the decision analytic decision aid—and other information sources—within a broad spectrum of factors to be weighed up as part of their own process of decision-making.

3.2. Ease of use and wider application of the decision aid

Generally, the respondents found the utility assessment easy to use and straightforward, although most acknowledged that choosing between the intermediate health state and the gamble was more difficult as the health state in question worsened:

“It was simple. Um, the questions were straightforward providing you read the bits above.” [I: Were there any bits that you found particularly difficult?] “Answering some of the questions towards the end, they made you think, wasn’t difficult but they did make you think. Easy to start with, the difficulty comes later on when option 2 changes.” [Respondent 2]

Indeed, most respondents described ‘seeing the point’ of going through the exercise at this juncture, when the decision between the two options was very close. That is, they recognised that the programme was forcing them to make a choice between two options whose value would be quite personally weighted. Nonetheless, some respondents found this frustrating and, in one case, quite tedious:

“To tell you the truth it was a bit boring in the end because all you were doing is going over the same thing time and time again. That was a bit monotonous, to tell you the truth.” [Respondent 14]

Overall, though, the respondents were able to relate this process to their own circumstances and quite appreciated the opportunity to clarify their own personal values regarding possible outcomes of high blood pressure:

“It was a great eye opener for me . . . . It allowed me actually to focus my mind truly on what was a heart attack and what was a stroke and what could happen to me, which I hadn’t actually done up until now, up until I did the programme.” [Respondent 9]

All of the respondents were in favour of having such computerised decision aids available to patients in a general practice surgery and their expansion into other
clinical areas. Although previous authors have expressed concern about the practical application of decision analysis in clinical practice [19], this study found a high level of patient acceptability. In the main trial, only three out of 99 who attempted to use the decision aid were unable to complete the interview [14]. However, whether the high level of acceptability in the current study was because respondents liked the decision analytic process per se or because it clarified personal values and gave information on individual cardiovascular event (CVE) risk is difficult to determine.

Most felt that having someone else present, to assist with the decision aid, would be helpful. The comment made by Respondent 12 was typical:

"I mean the older generation, I don’t know, there’s not all that many on computer, I don’t think. But they’d probably have to explain to them but the younger generation I think they could cope with that easy enough." [Respondent 12]

This is a 69-year old man who found the programme ‘quite straightforward’ yet had never used a computer before. Paradoxically, even older respondents who had never used a computer before spoke of the ‘older generation’ needing additional assistance when, at the same time, they themselves had found it quite straightforward to use. Should the use of such a computerised decision aid be more widely applied, it may be that the role of the ‘computer assistant’ would be more to allay an older person’s fears and preconceptions about computers rather than providing any substantial technical assistance.

3.3. Influence of the decision aid upon decision-making

One of the key issues was to explore how use of the decision aid affected respondents’ attitudes to taking anti-hypertensive medication and whether or not tablets were ultimately prescribed. In several respondents their pre- and post-intervention preferences for starting drug treatment and the outcome of the decision aid all broadly agreed (Respondents 1, 3, 7, 9, 10, 12, 15, Table 2). One respondent, initially unsure about taking tablets, described how the process of completing the decision aid made him more aware of the consequences of untreated high blood pressure and more amenable to taking tablets:

"But it did make me aware of what was happening . . . looks like I’ll end up taking the pill. Though I wasn’t sure until we went right through it he put it back through on what the computer ended up with . . . then I accepted the fact, you know, that it [taking tablets] was giving me a bigger chance." [Respondent 12]

For these respondents the actual prescribing of an anti-hypertensive followed their preference to take tablets, with the exception of Respondent 1 whose blood pressure had gone down.

For another group (Respondents 2, 8, 13, 14) the decision aid made them more aware of the disparity between their own preferences for taking medication and the clinical need for medication. These were reluctant medicine-takers who, having used the decision aid and reflected upon it, decided they would take tablets should their blood pressure remain raised:

"Whereas I would have [taken tablets]. If he’d have said your blood pressure’s above average, you’ve got to take tablets I would have taken them, against my will really." [Respondent 8]

These respondents were concerned about the risk of stroke should they remain untreated and that the need to take tablets may become inevitable. All these respondents were later prescribed anti-hypertensive treatment.

Equally, the decision aid could also be a catalyst for a change, causing a respondent who had previously been amenable to taking medicines to being more reluctant to take treatment:

"At that time [at first] I probably was much less informed than I am now and would probably say now that I would want to discuss it further before actually agreeing to go on to the tablets. Because of the, the level of blood pressure that I am sort of classified as—which I understand is borderline . . . I think it’s worth actually perhaps trying a change to lifestyle before actually taking the plunge and actually going onto tablets." [Respondent 6]

For this respondent the use of the decision aid prompted him to have more discussions with his doctor on other methods of managing high blood pressure (this respondent also received the video and leaflet as part of the main trial’s factorial design). The decision aid made him feel more empowered to discuss options with his GP and possibly decline treatment. In discussion throughout the interview it was evident that the decision aid prompted a significant re-think in how he considered tablet-taking in general, shifting him away from his previous unquestioning attitude of the past.

Respondent 11 was a particularly interesting individual, who was unsure as to whether or not she should take tablets, yet in the interview appeared to be quite a reluctant medicine-taker:

[I: Right, so the doctor has already started you on some tablets but you haven’t actually taken them yet?]

"No.”

[I: And so, are you going to start taking them before you see him or . . . ?]

“No, I’m going to go back and see what my blood pressure is next time then if it’s still the same then I might consider taking them. But I’m still not definitely decided, it all depends on the blood pressure." [Respondent 11]

The outcome of the decision analysis was to not take tablets. This individual was later prescribed medication by the GP and became non-adherent. This may be
an example of where the respondent’s preferences for medicine-taking were ignored, contributing towards them becoming non-adherent. This finding reinforces the work of Britten, who found an association between patients’ non-participation in the consultation and subsequent misunderstandings in prescribing. Comparable to the current study, Britten found that such misunderstandings could lead to adverse outcomes including non-adherence to treatment [20].

Finally, there were two respondents whose decision aid revealed apparent discrepancies to their stated preferences for taking tablets (Respondents 4, 5) and the interview offered no insight into their decision-making process. Both respondents stated they would like to start tablets but the outcome of the decision aid was to not take tablets. During the interview both mentioned that they had memory recall difficulties, although both also stated that they felt the decision aid had no effect on their decision-making. For these two respondents, the decision aid appeared less successful in capturing their preferences towards medicine-taking, though this may have partly been confounded by memory problems.

4. Discussion and conclusion

Semi-structured interviews were conducted with 15 newly diagnosed hypertensive patients to explore respondents’ perceptions of a decision analytic decision aid, including their views on where to access additional clinical information, the decision aid’s ease of use and the decision aid’s effect upon their preferences for taking medication. Respondents’ information-seeking attitudes featured prominently, with most seeking additional clinical information from friends, family, leaflets, books or the internet. Overall, respondents’ views on the decision aid were favourable, it was easy to use and all favoured its introduction more widely into practice. For many, it appeared to confirm and/or clarify their stated preferences towards medicine-taking. Occasionally the decision aid could provoke a major shift in a respondent’s attitude to medicine-taking. In a few respondents the decision aid had no discernible effect on their decision-making. In this respect it was difficult to determine whether patients enjoyed and benefited from the decision analytic process itself or whether they just wanted information, whatever the source or format.

4.1. Study limitations

Qualitative methods are an innovative approach in decision aid research that enable an insight into the patient’s view on the process and outcome of a decision analysis decision aid. In previous work, open questions on a questionnaire were used to explore patients’ attitudes towards decision-making after using a decision aid [13]. However, there are limitations to the current qualitative approach, most importantly in the area of bias. Although respondents were informed that the interviewer was not part of the main trial’s research team, and that their true opinion was being sought, they may have felt unable to be unduly critical of the decision aid. In addition, these respondents were recruited from participants in the main trial. This alone may make this group of respondents different from a typical patient population, possibly self-selecting individuals who would be more amenable to participating in decision-making. It clearly was also difficult for respondents to make suggestions for improvement to the decision aid. This could have been because they were generally satisfied with the process or because it was too difficult to envisage hypothetical improvements, having had only the one experience of using a decision aid. This study was also limited in that it only explored one factor (the computerised decision aid) influencing a patient’s willingness to take tablets. Other factors, such as the influence of the physician on the patient’s decision-making, were not investigated and may have affected the patient’s view of the decision aid. Finally, due to scheduling difficulties, respondents were interviewed between 2 h and 2 weeks after using the decision aid. Particularly for those for whom there was a considerable time delay after using the decision aid, there may have been poor recall of the decision aid and of what they were thinking at the time they used it and how it had affected their decision-making process.

4.2. Practice implications

Findings from this study suggest that the use of a decision aid in general practice appeared to work in different ways for different people. Some saw it as an information tool, making them more aware of the consequences of not taking treatment and suffering an adverse event. For others it brought sharply into focus the difference between their own preference to not take medication and the adverse consequences of high blood pressure. The decision aid could be a catalyst for change, making a respondent less amenable to taking tablets and empowering them to discuss these issues further with their GP before they would initiate treatment. Clearly, for a minority of patients, the decision aid will be difficult to use and be of limited value.

Respondents viewed discussing their condition with their GP and finding out more about treatment as two quite separate processes. The GP was not seen as a source of information, respondents preferred more informal, non-professional sources. For GPs to have a more prominent role in patient decision-making, they need to emphasise to patients their approachability, their role in providing unbiased information and their skills in synthesising information from a range of sources. GPs and other primary healthcare professionals are in an ideal position to provide this service and could use this role to maintain and enhance their relationships with patients.

Future research is needed to clarify whether the issues identified in this study can be generalised more widely to other clinical conditions. Patients’ perceptions of the role
of this decision aid were likely to be coloured by the nature of hypertension itself, as it is both asymptomatic and is unlikely to have immediate clinical sequelae. Conditions with more overt symptomatology or immediate clinical consequences are likely to be perceived differently by patients. The exploration of how patients’ decision-making changes over time, from new diagnosis to chronic treatment, and how a decision aid might influence this decision-making, would be particularly valuable.

References


