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Control preferences in treatment decisions among older adults — Results of a large population-based study

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ABSTRACT

Objective: Older adults appear to be a specifically vulnerable group that could benefit considerably from the assessment of their decision-making preferences. The aim of this study was to estimate prevalence rates and to explore characteristics of control preferences in a population-based sample of older adults.
Methods: Data was derived from the 8-year follow-up of the ESTHER study — a German epidemiological study in the elderly population. $n = 3124$ participants ages 57 to 84 were visited at home by trained medical doctors for a comprehensive assessment regarding various aspects of their life. The German version of the Control Preferences Scale (CPS) was used to assess decision-making.
Results: Most of the participants reported a preference for an active role in the decision-making process (46%, 95% CI [44.3; 47.9]), while 30.0% [28.4; 31.5] preferred a collaborative role, and 23.9% [22.4; 25.5] a passive role. Participants aged ≤65 years preferred a more passive role in decision-making compared to persons aged <65 years. Participants with clinically significant depression symptoms (CSD) preferred significantly more often a passive role compared to those without CSD. Similarly, multimorbid patients preferred a passive role compared to people with none or one chronic disease. Conversely, in groups with active or collaborative control preferences the morbidity index was lower compared to the group with passive control preferences.
Conclusion: Results indicate that physical and mental health in the elderly are associated with the preference role. It should, however, be investigated whether multimorbidity or mental diseases influence the treatment preference of older adults.

1. Introduction

In the past decades, the involvement of patients in treatment decision making has been of central interest. To date, many studies have investigated control preferences regarding decision making among patients and the possible benefits of involvement in decisions such as improved patient satisfaction and health outcomes [1,2]. Meanwhile the shared decision-making approach is a widely used method where both the consumer and provider are involved in providing information and decision-making [3,4].

1.1. Medical care and control preferences in the elderly

Among aging people, it is common to have more than one chronic condition. Results of a population-based study indicate that 67.3% of the German population aged 50 to 75 suffers from multimorbidity [5]. The co-occurrence of mental disorders frequently aggravates the course of multimorbidity in older age [6–8]. When taking into account their experience of many social challenges, older adults appear to be a specifically vulnerable population that is more likely to face complex medical decision making. They could therefore benefit considerably from the assessment of their preferences: whether or not to participate in treatment decision making. Due to a higher bio-psycho-social burden, it is possible that older adults differ from younger adults in regard to their treatment preferences; it is also conceivable that treatment preferences change in advanced age along with other changing conditions. Understanding the control preferences and their associated factors in older people could help us to better deal with complex medical situations as well as improve the individualization of both care and clinical outcomes [9–11]. However, to date, studies that have evaluated the

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control preferences of older adults are scarce. Furthermore, previous studies regarding control preferences have largely investigated selected patient samples. To date, there are only a few studies that have investigated the associations between control preferences and multimorbidity or mental disorders in a large sample of older adults [5].

1.2. The Control Preferences Scale

The Control Preferences Scale (CPS) [12] is a reliable and widely used instrument to measure patients' decision making preferences regarding medical treatment. The Control Preferences Construct is defined as "the degree of control an individual wants to assume when decisions are being made about their medical treatment" (p. 21). Thus, according to this definition, the control preferences of individuals differ from their request for information.

Studies that used the CPS in various patient groups (e.g. cancer, asthma, hepatitis C) revealed inconsistent results regarding the factors that influence preferences of patients. Most studies reported that the younger and better educated patients – and women – more often preferred an active role in decision-making compared to older or less educated patients or men [13–17].

However, other studies failed to show that gender, age, or educational status were significantly associated with control preferences [18]. Anderson et al. [19] found an association between control preferences and mental disorder symptoms in intensive care unit patients: the more passive the role in decision-making, the higher the amount of anxiety and depressive symptoms. Moise et al. [20] found similar results in patients with depression and a comorbid illness. Results of other studies [21–23] indicated that most adult patients with mental illnesses preferred a collaborative role in decision-making.

Regarding multimorbidity Schneider et al. [24] reported that patients with chronic and severe diseases had the lowest scores in preference for participation in the medical decision-making process. Efficace et al. [17] found that patients with at least one comorbid disease preferred significantly more collaborative or passive control in the decision-making process than active ones.

2. Purpose

The objectives of the present study were, (a) to estimate the prevalence rates of the various control preferences (active, passive, collaborative) and (b) to determine the associations between control preferences, demographic factors, mental disorders, and multimorbidity in older adults. We hypothesized that decision-making preferences according to the CPS would be related to age group, sex, educational status, and multimorbidity. Furthermore, we hypothesized that older adults with depressive symptoms would more often prefer a passive role in decision-making than participants without depressive symptoms.

3. Method

3.1. Study sample

The data were derived from the eight-year follow-up of the ESTHER study — a population-based cohort study of older adults in Germany [25,26]. The study was approved by the ethics committees of the University of Heidelberg and of the medical board of the state of Saarland, Germany. Informed written consent was obtained from all participants.

At the baseline of the ESTHER study (between July 2000 and December 2002) in the federal state of Saarland, 9949 participants were recruited by their general practitioners in the course of a health check-up that is offered biennially to older adults in Germany. The ESTHER study sample was shown to be representative with respect to both demographic variables and chronic diseases of the general German population [27]. Follow-ups were conducted 2, 5, and 8 years after recruitment.

At the beginning of the 8-year follow-up of the ESTHER study 8770 participants were still alive. Of these, 505 participants were not able to complete a standardized questionnaire — leaving 8265 possible participants. All in all, between 2008 and 2010, 6086 older adults participated in the third 8-year follow-up. All participants of the eight-year follow-up were asked if they would take part in a longer home visit to be conducted as personal interviews and a geriatric assessment. Of the 6086 ESTHER participants, 3124 (51.3%) agreed to be visited at home. The home visits served as a comprehensive assessment tool regarding functional status and control preferences, as well as medical, pharmacological, socio-economic, and psychosocial aspects of their life.

3.2. Measurements

The German version of the Control Preferences Scale (CPS) [12,28] was used to assess the decision-making preferences of the home visit participants. The CPS was developed by Degner et al. [12] to assess the preferences of patients regarding their role in treatment decision making. It consists of five cards, each of them with a statement and drawing about decision making preferences ranging from fully active to fully passive. In our study, we added headings in capital letters on the cards to facilitate understanding for the older adults. The headings were approved by two experts of the shared decision-making research. Fig. 1 shows the five CPS cards used in our study.

The CPS has been evaluated in a variety of patient populations, e.g. cancer [14], chronic hepatitis [15] or elderly patients [29]. It has been demonstrated to be a useful, easily understandable and administered, reliable instrument that generates valid data to measure patients' preferences regarding medical decision making [30,31].

We adapted Zhang's method [15] to administrate the CPS: The study doctors showed the participants the five cards and asked to bring them into a rank order. The first card in each ranking order represents the patients' most preferred role whereas the last card represents the least preferred role the patient wishes to have in medical decision-making. For example, EDCBA represents the preference order of persons that strongly desire to leave all decisions regarding their treatment up to their doctor.

3.3. Covariates

Depressive symptoms were assessed using the 8-item Patient Health Questionnaire depression scale (PHQ-8) [32].The PHQ-8 consists of eight of the nine Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) - diagnostic criteria for major depressive disorder. Scores of the PHQ-8 range from 0 to 24, with higher scores indicating a higher severity of depressive symptoms. Test-retest reliability of the PHQ depression module ranged between 0.81 and 0.96 [33]. A cut-off point of ≥10 is recommended for the detection of any depressive disorder, demonstrating a sensitivity of 87% and a specificity of 76% [34]. Participants with a score ≥ 10 were defined as having clinically significant depressive symptoms (CSD).

Self-perceived cognitive impairment was assessed by the three following questions: (1) "Lately, I often confuse names, phone numbers, and dates", (2) "I've often been misplacing things lately ", and (3) "I often forget names and numbers lately "(0 = no; 1 = yes, sometimes; 2 = yes, often, always).

Chronic illness burden was rated by the general practitioners of the respondents by using the Cumulative Illness Rating Scale for Geriatrics (CIRS-G) [35]. The CIRS-G is based on the Cumulative Illness Rating Scale [36] which is a well-established measure of multimorbidity. 14 categories refer to clinically relevant physiological systems and psychiatric illnesses: 1. heart, 2. vascular, 3. hematopoetic, 4. respiratory, 5. eyes, ears, nose, throat and larynx, 6. upper gastrointestinal tract, 7. lower gastrointestinal tract, 8. liver, 9. renal, 10. genitourinary, 11.