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Editorial

Providing patients with information about treatment choices: do unto others?†

Mike J. Crawford and Eoin Dunlea

Summary
A variety of internal and external pressures may lead psychiatrists to promote intensive or intrusive treatments. However, when asked what treatment they would want for themselves they seem more likely to opt for less intensive treatments or no treatment at all. These differences highlight the importance of providing patients with enough information to enable them to make a fully informed choice about the treatment they receive.

Declaration of interest
None.

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When healthcare staff are asked whether they treat patients the same way they themselves would want to be treated, they generally state that they do.[1] The rationale for this approach seems clear; if a treatment is good enough for an informed healthcare practitioner to want for themselves, it should be good enough for the patients they treat. Different versions of this basic ethical principle of treating people the way that you would want them to treat you have been encountered in so many different cultures and historical periods that it has even come to be known as the Golden Rule.[2] However, findings from more recent surveys of mental health practitioners have challenged the notion that this principle is actually applied in clinical practice. Such studies reveal that many mental healthcare practitioners would not want to be given the types of treatments that may be given to their patients. For example, a survey on attitudes to advanced directives among 101 mental health nurses and psychiatrists in Austria, found that 45% would not want to be treated with electroconvulsive therapy.[3] A third of respondents stated that they would not want to be treated with antipsychotics even if they lacked insight and a doctor determined that this was the most appropriate treatment for them. Many of those who stated that they would never want to be treated with antipsychotic medication expressed a preference for treatment with benzodiazepines. However, as respondents in this study were not asked about their own prescribing practices we do not know if this is a treatment option that was generally given to the individuals that they treat.

In this issue of the *Journal*, Mendel and colleagues present findings from a randomised trial of the influence of patient requests for information on the treatments that psychiatrists recommend.[4] The findings of this novel study provide an interesting insight into whether psychiatrists follow the Golden Rule in practice and why we may choose to treat patients differently.

Treating patients differently

Mendel *et al*'s study involved a cross-sectional survey of an opportunistic sample of over 500 German psychiatrists recruited during an annual conference. Participants were given one of two vignettes and asked to state which treatment they would recommend. In the first vignette, a brief account of a person with depressive symptoms was provided and respondents were asked to choose between prescribing an antidepressant or 'watchful waiting'. The second vignette was of a person with schizophrenia who is experiencing a relapse and sometimes forgets to take their medication. Respondents were asked to make a choice between prescribing oral or depot antipsychotic medication. Participating psychiatrists were randomly allocated to one of three groups in which they were asked to state how they would generally treat a patient, how they themselves would wish to be treated, or how they would respond to the request from a patient: 'What would you do if you were me, doctor?'.

Surveys of attitudes and beliefs can never be free from the risk of response bias, especially from the possibility that participants will give responses that they believe are socially acceptable. However, by using a randomised design, Mendel and colleagues were able to contrast the views of separate but comparable groups of psychiatrists about how they treat patients and how they would wish to be treated themselves. The study highlights the value of randomised designs when exploring attitudes and beliefs and their findings provide clear evidence that psychiatrists generally do not want to be treated in ways that their patients often are treated. For instance, almost half of the psychiatrists stated that they would advise a patient who sometimes forgets to take oral antipsychotic medication to start treatment with a depot antipsychotic, whereas only 15% would want to take depot antipsychotic medication if they had psychosis and sometimes forgot to take their medication. When asked how they would respond to the question: 'What would you do if you were me, doctor?', an even greater proportion stated that they would tell the patient that they would take depot medication than those who stated that this is what they would do in their normal clinical practice.

As this was a survey of psychiatrists' beliefs, we do not know whether the responses given match up with the treatments that respondents actually prescribe, let alone whether preferences for personal treatment would be the same should those who took part actually need them. Vignette-based studies such as this one can also be criticised for not providing respondents with the type of detailed information that they would usually have when making

†See pp. 441–447, this issue.

clinical decisions. The vignette the team used to explore the treatment of someone with schizophrenia was very brief and did not include information about factors such as risk, social support and other factors that may be taken into account when making a decision about whether to recommend oral or depot antipsychotic medication in clinical practice. When treating people with severe mental illness psychiatrists may have to consider the impact of the patient's problems on others[5] and it is possible that this may have contributed to the higher proportion recommending depot treatment. However, it is hard to see how such considerations could be responsible for psychiatrists recommending anti-depressant treatment for symptoms of depression, when their own preference was more likely to be 'watchful waiting'. So why might psychiatrists appear to want treatments for themselves that are different from those they offer the patients they treat?

Pressure to treat

In trying to explain why psychiatrists were more likely to recommend active or intrusive treatments for their patients than for themselves, the additional information that Mendel and colleagues collected on beliefs about the positive and negative effects of different treatments may be pertinent. These data show that, when considering treatments for patients, respondents were more likely to emphasise the benefits of treatment. A desire to alleviate distress and suffering may provide a powerful incentive for healthcare staff to advise a patient to accept a more intensive or intrusive treatment. Although there has been much discussion about the reasons why people choose a career in healthcare, both a desire to help and a desire to play an important role in making a difference have been described by those considering a career in medicine.[6] In helping clinicians to fulfil these aims it has been argued that 'cured patients do a great service to their attendants'.[7] Indeed, 'the best kind of patient for this purpose is one who, from great suffering . . . responds quickly to a treatment that interests his doctor'.[7] In contrast, patients who prefer less intensive treatments or an approach of waiting to see what happens without active treatment may challenge the ability of healthcare practitioners to fulfil their aim of being helpful and making a difference.

The pressure to treat is also fuelled by those championing new psychological and drug treatments and by the commercial interests of pharmaceutical companies. The extent to which promoting such treatments influences clinical practice has been much debated, but whatever the impact, it is not balanced by campaigns or adverts promoting a more conservative approach to treatment.

Mendel and colleagues also found that psychiatrists placed a greater emphasis on the negative effects of treatment when considering their own treatment, compared with that of a patient. They suggest that this difference might be explained by their focusing on the mental health of patients, meanwhile holding wider concerns about the inconvenience, side-effects and other negative aspects of taking medication when considering how they would want to be treated. If true, this would imply that, when advising patients, psychiatrists use a disease-focused approach,[8] but that when considering their own treatment they take a more 'patient-centred' one.[9] Although the latter approach has its critics within psychiatry, available evidence suggests that patients prefer a broader approach to considering their health-related problems and needs.[10] Providing information on 'options for treating or managing their condition, including the option not to treat' is also central to recommendations on good medical practice.[11]

Patient choice

Providing patients with information to help them make treatment decisions is not an easy task. It takes time, and may result in them choosing treatments that differ from the ones that we would prefer them to have.[12] Financial pressures faced by healthcare services in many countries may reduce the amount of time psychiatrists have to elicit patient preferences and provide the information they need to make an informed choice. A drive towards outcome measurement in routine clinical care may pressure psychiatrists into a role of persuading people to take the treatment they believe will be most effective in reducing their symptoms. In this context the findings of the study by Mendel and colleagues remind us that, when wider issues regarding treatment are taken into consideration, people may prefer a less intrusive treatment or no treatment at all.[13]

Ultimately there may be grounds for rejecting the Golden Rule. As George Bernard Shaw is said to have advised 'Do not do unto others as you would expect they should do unto you – their tastes may not be the same'. The preferences of psychiatrists asked to consider their own treatment may also be different from those they would hold were they to become unwell. Nonetheless, the findings from this survey highlight the importance people place on the negative as well as the potentially positive effects of treatments. In trying to understand why many patients do not follow the advice of their psychiatrist, it may be worth bearing in mind the question: 'What would I want to do if I were in their position?'.

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