23

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PREFERENCES FOR INVOLVEMENT IN URINARY INCONTINENCE TREATMENT DECISION-MAKING AMONG NORWEGIAN WOMEN

Hypothesis / aims of study
To explore women's preferences for involvement in treatment decision-making for urinary incontinence (UI) and factors associated with role preferences.

Study design, materials and methods
A national telephone survey of 1000 randomly selected Norwegian women aged 18 years or over. The Control Preferences Scale (CPS) was used to elicit women's preferences for involvement in UI treatment decision-making (1). Women were asked to select one of five responses that best described the extent to which they wanted to be involved in UI treatment decision-making (Box 1). Other data collected included women's experience of UI, self-perceived knowledge of UI treatments, general health status and demographics. Age was categorized into three age groups: 18-44, 45-59 and 60 years and over. We also combined some of the categorical variables to ease the interpretation of results.

Box 1
Imagine you have to make a decision about treatment for leakage of urine. Which one of the following five statements describes best how you would like a decision about treatment for leakage of urine to be made?

I prefer:

A. To make the decision on my own.
B. to make the decision after considering my doctor's opinion.
C. that my doctor and I share responsibility for making the decision.
D. that my doctor makes the decision after considering my opinion.
E. that my doctor makes the decision on his/her own.

Bivariate and multivariate analyses were conducted to explore factors associated with UI treatment decision-making preferences. All factors found to be associated at the $p < .1$ level in bivariate analyses were included in multivariate analyses and the likelihood of choosing an active role or a passive role compared to a collaborative role was explored. For bivariate and multivariate analyses the dependent variable, women's preferences for involvement in treatment decision-making was categorised into 3 groups, active (A + B), collaborative (C) and passive (D + E). Statistical significance was accepted at the 5% level.

Results
A total of 981 women selected one of the five responses to describe their role preference in UI treatment decision-making. Sixty per cent of women preferred an active role, 23% a collaborative role and 17% a passive role in treatment decision-making for urinary incontinence.

Factors associated with role preferences for UI treatment decision-making using bivariate analyses are shown in Table 1. Women aged 60 or over were less likely to prefer an active role and those with a higher education and very good general health were more likely to prefer an active role. Women with no knowledge of UI treatments were more likely to prefer a passive role. No significant association was found for women's experience of UI and preferences for involvement in UI treatment decision-making.

Table 1 Factors associated with UI treatment decision-making preferences (%)

	ROLE PREFERENCES			
	Active	**Collaborative**	**Passive**	**p**
UI treatment decision-making				
Age group				<0.005
18-44 yrs	61	21	17	
45-59 yrs	67	21	12	
60+ yrs	49	30	21	
Education level				<0.001
Mandatory/High School (10-12 yrs)	51	27	21	
Further/University (13+ yrs)	65	21	13	
Marital status				.236
Married/Partner	61	23	15	
Divorced/Widowed/Single	57	24	20	
General health status				<0.05
Poor/not so good	55	28	16	
Good	57	24	19	

Very good	67	20	13	
Urinary incontinence				.956
Yes	61	23	16	
No	60	24	17	
Self-perceived knowledge of UI				
Extensive	59	25	16	<0.001
Some/Little	64	23	13	
None	51	24	25	

Only age group and education remained significantly associated with role preferences in multivariable analyses with women aged 60 or over less likely to prefer an active compared to a collaborative role and those with a higher education more likely to prefer an active compared to a collaborative role.

Interpretation of results

The majority of women want to play an “active” role in UI treatment decision-making with older women less likely and those with a higher level of education more likely to prefer an active role in UI treatment decision-making. Previous research suggests that prior experience of an illness can influence role preferences (2) but our study did not show significant differences in role preferences for involvement in UI treatment decision-making between women with and without UI. Knowledge of a condition may also hinder involvement in treatment decision-making (3). However, we found no association between self-perceived knowledge of UI treatments and role preferences after controlling for other factors suggesting knowledge of UI treatments does not influence role preferences in this clinical scenario to the extent that other factors do.

Concluding message

The majority of Norwegian women prefer an active role when considering UI treatment decision-making with older women less likely and more educated women more likely to prefer an active role.

References

1. Can J Nurs Res (1997) 29:21-43.
2. Arch Intern Med (2000) 160:2991-6.
3. Soc Sci Med (1994) 39:279-89.

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HUMAN SUBJECTS: This study did not need ethical approval because There was no patient-doctor relationship or any other relation between the study investigators and the persons contacted in the study. but followed the Declaration of Helsinki Informed consent was obtained from the patients.