Original Article

Are Iranian patients willing to receive clinical information and participate in treatment

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Abstract

This study examined the extent to which patients are willing to receive medical information about their health status and participate in medical decision-making. It also assessed the patients' satisfaction with the amount of information provided to them and their involvement in treatment decisions. Additionally, the study evaluated differences between patients' and their companions' perspectives on the necessity of informing patients about their health status. This cross-sectional study included 110 eligible patients, who were interviewed using a developed and validated questionnaire.

The results revealed that Iranian patients exhibited a relatively high tendency to seek information and participate in medical decision-making. This tendency was more pronounced among women, married individuals, and patients hospitalized in private hospitals. Additionally, the companions' inclination to inform patients about their clinical condition was lower than the patients' own desire to be informed. The study concluded that doctors should create an appropriate environment for informing patients and facilitating their active participation in decisions.

Furthermore, the decision regarding the extent of information provided to patients should be left to the patients themselves.

Keywords: *Patient rights; Clinical decision making; Patient access to records.*

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Introduction

Decision-making involves two stages: assessment and selection. First, the available options must be identified, and then the option most be aligned with an individual's goals, desires, and values—while offering the highest probability of success or impact—is chosen (1). One of the most challenging domains of decision-making is health and medical treatment. A person's acceptance of their illness, the decision to seek medical advice, and adherence to the doctor's recommendations serve as clear examples of this process (2).

In recent decades, there has been growing attention to patient autonomy and the need for healthcare professionals to prioritize it (3). Informing patients about their health status and involving them in treatment decisions are fundamental principles of patient-centered care. Consequently, numerous studies have been conducted to assess patients' preferences for receiving information and participating in treatment decisions (4).

Several studies have shown that respecting patients' autonomy by informing them about their health status and involving them in the treatment process not only leads to positive psychological effects and higher satisfaction but also improves their physiological condition. Research indicates that the more actively patients participate in decision-making, the more consistently they attend routine check-ups, undergo screening tests, or receive vaccinations. Additionally, health-oriented lifestyles, such as maintaining a proper diet and engaging in regular exercise, are more prevalent among these patients. Studies also highlight that patients actively involved in their treatment process are more likely to avoid harmful behaviors, such as smoking, follow their doctor's recommendations, and practice self-care compared to passive patients (5-7).

Other studies investigating the therapeutic effects of patient involvement in the treatment process have confirmed that better clinical outcomes are achieved when patients are included as part of the decision-making team. For instance, one study demonstrated that health indicators such as body mass index, hemoglobin A1C, blood pressure, and cholesterol levels are more favorable in patients actively involved in their treatment process compared to others (8).

Some studies have also affirmed the positive effect of patients being active in the treatment process of various diseases, such as diabetes and AIDS, in achieving better treatment outcomes (9, 10).

The concept of interacting with consumers of health and medical services is not a novel issue, but creating an environment in which patients can participate in decision-making is a relatively new topic. Patient participation in the treatment process significantly increases patient satisfaction, while also reducing anxiety and negative emotions through enhanced trust in treatment (11, 12).

Asghari et al. conducted a study in this field in 2008 (13). In this study, 312 eligible patients admitted to the general internal medicine or surgery wards between May and December 2006 were interviewed using a structured questionnaire. The results showed that Iranian patients are highly interested in receiving information about their condition and participating in clinical decision-making. No predictive variables for such attitudes were identified. The authors concluded that the only way for physicians to understand patients' desires is to ask them explicitly (13). This study is one of the few indigenous studies on this matter, conducted in a specific time period and in a cultural context different from that of Isfahan. Most other studies have focused more on the effectiveness of patient participation rather than the willingness of individuals to participate in their treatment process (14–16).

Since few studies have been conducted on evaluating the views of Iranian patients, this study was carried out in selected hospitals in Isfahan to investigate hospitalized patients’ willingness to be informed about their health status and participate in the treatment process, as well as to identify the factors influencing this willingness. The results of this study can provide valuable insights for health system authorities in designing and implementing educational programs tailored to the needs of patients.

Method

Study type, place, and time

A descriptive, analytical, cross-sectional study was conducted on hospitalized patients in selected hospitals of Isfahan University of Medical Sciences between February 2022 and June 2022. The sample size was determined to be 110 cases using the sample size equation, with an alpha error of 5%. The standard deviation of the propensity score (based on VAS) was 1.6, and the value of d was 0.3.

The inclusion criteria consisted of having the capacity to make decisions, being at least 18 years old, and providing verbal consent to participate in the study. The exclusion criteria involved the presence of cognitive disorders, moderate-to-severe pain, and leaving more than 20 percent of the questionnaire unanswered. The details of the study were fully explained, and the participants were provided with a comfortable platform for any questions they might have.

Questionnaire items

The questionnaire used in this study was initially designed and validated by Asghari et al. to assess patients' preferences for medical information and their involvement in decision-making. To ensure its validity, Asghari et al. had the questionnaire reviewed by an expert panel and evaluated its face validity through patient interviews. They also demonstrated excellent internal consistency, with a Cronbach's alpha of 0.89 for the entire questionnaire. This high Cronbach's alpha value confirmed that the questionnaire reliably measures patient preferences for medical information and participation.

The questionnaire consisted of 11 items, including patients' desire to learn the diagnosis, desire to learn treatment or diagnostic options, desire to know the advantages and disadvantages of different options, desire to learn the consequences of avoiding treatment, desire to participate in decision-making, satisfaction with involvement in decision-making, satisfaction with information received, patient's estimation of the degree of involvement provided by physicians, desire for the companion to learn about their condition, and companions' desire for the patient to learn about their condition.

The questionnaire contained a spectrum of 10 degrees for each item, where on one side, the lightest color represented strong disagreement, and the darkest color on the other side represented absolute agreement. This spectrum also included numbers from one to ten, spaced one and a half centimeters apart, to show the lowest to the highest degree of tendency. The visual analog scale (VAS) was used to measure the willingness and satisfaction of patients to receive information and participate in the process of diagnosis or treatment because this method was relatively easy to understand and use, particularly for people who were illiterate. To facilitate the evaluation of the scores, participants' answers were categorized into three groups: 1–3 points were considered low, 4–7 points were considered medium, and 8–10 points were considered high.

Data collection

After obtaining the ethics code IR.MUI.MED.REC.1401.046, our team was granted approval by Al-Zahra, Kashani, Milad, Sepahan, and Saadi hospitals to access qualified patients. Given that factors such as socioeconomic status, educational level, and cultural background may influence participants' responses, half of the study participants were selected from private hospitals, while the other half were selected from public hospitals. Before starting, the patients were provided with necessary explanations about the purpose of the study and the VAS method used in the questionnaire. They were assured of the confidentiality of their information. Additionally, it was explained that completing the questionnaire would be considered informed consent to participate in the study. The patients read and answered the questions in the presence of our team members, who were available to clarify any questions.

Statistical analysis

Data were entered into SPSS 28 software. The non-parametric Kruskal-Wallis test was used to examine the difference in the values obtained from the questionnaire by background variables. Additionally, Pearson's correlation test was used to check the correlation between the subscales of the questionnaire

Results

A total of 110 participants were included in the study, of whom 59 (55.7%) were women, and the majority were over 46 years old (52.3%) (Table 1).

Table 1: Demographic information of the participants

		Percent
Age (Prevalence percentage)	18 to 30 years	20.6
	31 to 45 years	27.1
	46 to 60 years	22.4
	61 to 82 years	29.9
Gender (Prevalence percentage)	Male	44.3
	Female	55.7
Marital status (Prevalence percentage)	Married	72.0
	Single	28.0
Years of education (Prevalence percentage)	illiterate	8.7
	1 to 5 years	22.3
	6 to 12 years	32.0
	13 to 16 years	16.5
	Over 16 years	20.4
The type of action desired for the patient	Therapeutic	45.7
	Diagnostic	1.9
	Diagnostic-therapeutic	52.4
Type of hospital (Frequency percentage)	Educational	51.4
	Private	48.6

The questionnaire provided to the participants included two parts. The first part requested demographic information, including sex, age, marital status, level of education (according to years of education), type of medical procedure, and type of hospital. The second part consisted of 11 questions, as presented in Table 2.

Table 2: Scores related to questions from patients

Number	Severity (Percentage of frequency)				Scores median (range)
		Low	Moderate	High	
1	Would you like your physician to inform you of the probable diagnosis of your disease?	0	7.4	92.6	10 (5)
2	Would you like your physician to inform you of diagnosis and treatment options?	0	7.4	92.6	10 (5)
3	Would you like your physician to inform you of the advantages and disadvantages of the diagnosis and treatment options?	0	10.2	89.8	10 (6)
4	Would you like your physician to inform you of the consequences of refusing diagnostic procedures and treatment?	0	7.5	92.5	10 (6)
5	Would you like your physician to involve you in the decision- making process?	10.2	13.0	76.9	10 (9)
6	How satisfied are you with the information your physician provided?	16.0	27.4	56.6	8 (9)
7	How far did your physician involve you in decision-making?	26.9	23.1	50.0	7.5 (9)
8	How satisfied are you with being involved in decision-making?	22.2	20.4	57.4	8 (9)
9	How would you estimate your disease severity?	4.6	48.2	47.2	7 (9)
10	How much would you like your companion to be informed of your condition?	8.4	10.3	81.3	10 (9)
11	How much would you like the patient to be informed about his/ her disease? (asked of the companion)	13.5	19.2	67.3	10 (9)

According to Table 3, which compares age, education, type of therapeutic diagnostic action, gender, marital status, and type of hospital, it can be concluded that statistically, the willingness to learn about the possible diagnosis of the disease is relatively higher in individuals with a lower level of education (significance level = 0.001) and in women (significance level = 0.041) compared to others.

Table 3: comparison of the differences in mean scores of the questions by background variables

Variables		Mean (SD) scores										
		1	2	3	4	5	6	7	8	9	10	11
Gender	Male	9.3 (1.4)	9.4 (1.2)	9.2 (1.5)	9.4 (1.2)	7.8 (3)	7.3 (3)	6.2 (3.3)	6.8 (3.1)	6.9 (2.3)	9 (2)	8.5 (2.4)
	Female	9.8 (0.8)	9.7 (0.8)	9.5(1.2)	9.4 (1.3)	8.8 (2.4)	6.9 (3.1)	6.4 (3.6)	6.7 (3.5)	7.3 (2.3)	8.3 (2.9)	7.3 (3.3)

	P-value*	0.041	0.20	0.60	0.87	0.011	0.44	0.59	0.67	0.29	0.61	0.16
Age	18 to 30	9.3 (1.5)	9.4 (1.2)	9 (1.6)	9 (1.8)	8.7 (2.3)	6.5 (3.4)	6.7 (3.4)	6.3 (3.5)	6.6 (2.3)	8.6 (2.7)	6.8 (3.5)
	31 to 45	9.3 (1.3)	9.5 (0.9)	9.4 (1.1)	9.3 (1.1)	8.7 (2.4)	7.4 (3)	6.3 (3.1)	7.6 (2.9)	6.9 (2.1)	8.2 (2.7)	8.6 (2.3)
	46 to 60	9.6 (0.9)	9.7 (0.7)	9.1 (1.5)	9.3 (1.5)	8.2 (3)	7.3 (2.7)	5.9 (3.6)	6.5 (3.2)	7.7 (2)	8.2 (3.1)	7.8 (3.1)
	61 to 82	9.9 (0.6)	9.8 (1)	9.7 (1.1)	9.9 (0.4)	7.9 (3.1)	7.1 (3.2)	6.4 (3.9)	6.6 (3.6)	7.3 (2.6)	9.3 (1.7)	8 (3.1)
	P-value*	0.12	0.18	0.057	0.04	0.91	0.90	0.75	0.60	0.44	0.45	0.56
Marital status	Married	9.4 (1.4)	9.6 (0.9)	9.2 (1.4)	9.2 (1.6)	8.6 (2.2)	7.8 (2.7)	7.6 (2.4)	8 (2.5)	6.9 (2.4)	8.2 (3.1)	7.3 (3.2)
	Single	9.6 (1)	9.6 (1)	9.4 (1.3)	9.5 (1.1)	8.3 (2.9)	6.8 (3.2)	5.9 (3.7)	6.3 (3.5)	7.2 (2.2)	8.8 (2.3)	8.1 (2.9)
	P-value*	0.53	0.86	0.47	0.32	0.97	0.11	0.048	0.023	0.58	0.71	0.172
Education	Illiterate	10 (0)	10 (0)	10 (0)	9.9 (0.3)	6.7 (4.1)	8 (3.1)	7.1 (3)	8.2 (2.9)	6.9 (2.5)	8.2 (3.2)	7.8 (2.8)
	Primary	9.9 (0.3)	9.6 (1.1)	9.4 (1.6)	10 (0.2)	8.1 (3)	7.8 (2.5)	6.7 (3.5)	7.3 (3)	8.2 (1.8)	8.9 (2.6)	6.7 (3.6)
	Secondary	9.4 (1.5)	9.7 (0.9)	9.1 (1.7)	9.2 (1.6)	9.1 (2)	6.6 (3.3)	5.7 (3.8)	6.3 (3.7)	6.5 (2.6)	8.8 (2.8)	7.9 (3.5)
	Bachelor	9.8 (0.7)	9.8 (0.6)	9.8 (0.5)	9.8 (0.5)	8.4 (3.1)	6.1 (3.4)	5.8 (3.7)	6.6 (3.5)	6.8 (2.5)	9.4 (0.9)	8.8 (2.4)
	Masters and above	9 (1.3)	9 (1.3)	9 (1.1)	8.8 (1.4)	8.1 (2.4)	7.5 (2.7)	7.3 (2.6)	6.9 (2.9)	7.4 (1.7)	7.3 (2.6)	8.7 (1.4)
	P-value*	0.001	0.012	0.007	0.001	0.12	0.47	0.62	0.50	0.09	0.001	0.28
Action	Diagnostic	10 (0)	10 (0)	9.5 (0.7)	10 (0)	9.5 (0.7)	8 (2.8)	7.5 (2.1)	8 (2.8)	7.5 (2.1)	5.5 (6.4)	10 (0)
	Therapeutic	9.5 (1)	9.4 (1.2)	9.4 (1.3)	9.4 (1.1)	8.2 (2.7)	7.6 (2.8)	6.6 (3.4)	7.2 (3.1)	7.6 (2.1)	8.3 (2.7)	8.4 (2.6)
	Diagnostic and therapeutic	9.5 (1.2)	9.7 (0.8)	9.4 (1.4)	9.4 (1.3)	8.5 (2.8)	6.5 (3.2)	6.1 (3.6)	6.3 (3.5)	6.7 (2.4)	9 (2.3)	7.3 (3.3)
	P-value*	0.44	0.14	0.89	0.65	0.67	0.32	0.85	0.48	0.06	0.036	0.20
Hospital type	Educational	9.5 (1.3)	9.7 (0.9)	9.4 (1.3)	9.4 (1.4)	8.2 (3.1)	6.5 (3.3)	5.8 (3.7)	6 (3.6)	6.9 (2.5)	8.9 (2.5)	8 (3)
	Private	9.6 (0.9)	9.5 (1)	9.3 (1.4)	9.4 (1.1)	8.5 (2.3)	7.7 (2.7)	6.9 (3.1)	7.7 (2.8)	7.3 (2.1)	8.4 (2.6)	7.8 (3)
	P-value*	0.50	0.54	0.41	0.17	0.41	0.05	0.18	0.018	0.30	0.020	0.39

With an increase in the level of literacy, the degree of willingness to learn about various diagnostic and treatment methods (significance level = 0.012), the degree of desire to learn about the positive and negative aspects of various diagnostic and treatment methods (significance level = 0.007), and the degree of desire to learn about the consequences of refusing diagnostic and treatment methods decreased (significance level = 0.001).

In addition, for the question regarding the willingness to be informed about the patient's condition (significance level = 0.001), a negative correlation was found with the level of education, which was determined by the Bonferroni test to account for the possibility of false positives. Only two questions, the second and ninth, were meaningful. They were significant in the elementary and master's/higher education groups and in the bachelor's and master's education groups, respectively. In both cases, the educational level and willingness were negatively correlated. The level of desire to know the consequences of refusing diagnostic and treatment methods, in addition to the education level, also had a significant direct relationship with increasing age (significance level = 0.001).

The desire to participate in the decision-making process was higher among women than men ($P = 0.011$). The patients' estimation of their participation and satisfaction with decision-making was higher in married individuals than unmarried ones, and this difference was statistically significant (significance level = 0.048, significance level = 0.023). Statistically, the level of satisfaction with participation in the decision-making process for diagnosis and treatment, in addition to marital status, was also dependent on the type of hospital. This satisfaction was higher among patients in private sector hospitals (significance level = 0.028). The companions' willingness to inform patients about their illness had a direct and significant relationship with an increase in patients' education level, the therapeutic nature of the action, and being hospitalized in a government hospital, with significance levels of 0.001, 0.036, and 0.020, respectively. No significant differences were observed in the remaining cases. Pearson's correlation test was used to examine the relationship between the subscales of the questionnaire, and the results are shown in Table 4.

Table 4: The correlation between the subscales of the questionnaire (Pearson's correlation test)

	1	2	3	4	5	6	7	8
1. The degree of willingness to receive clinical information	1							
2. The level of willingness to participate in decision-making	0.122	1						
3. The level of satisfaction with information received	0.097–	0.01	1					
4. The level of patient perception of participation in decision-making	0.004–	0.136	*0.579	1				
5. The level of satisfaction with participation in decision-making	0.002	0.024	*0.766	*0.677	1			
6. The degree of the desire to be informed by the companion about the condition of the disease	0.115	0.035-	0.012-	0.041-	0.015	1		
7. The degree of the desire by the companion to inform the patient about the condition of his disease	0.047	0.032	0.004	0.042	0.030	0.061	1	
8. The degree of the perception of the patient from the severity of his illness	0.123	0.046	*0.328	*0.271	*0.267	0.010	- 0.011	1

**The significance level is less than 0.05*

In the correlation between the subscales of the questionnaire, it was observed that the patient's satisfaction with the information received was positively correlated with the estimation of their participation in decision-making and the patient's perception of the severity of their illness. Additionally, the level of satisfaction with participation in decision-making had a significant and positive relationship with the patient's perception of the severity of their illness.

Discussion

The results of our study showed that most of the participants (approximately 50 to 90 percent for each sub-scale) had a considerable willingness to receive medical information, which decreased with increasing educational level. Additionally, most of the patients exhibited a moderate to high desire to participate in decisions related to the treatment of their disease. Most patients reported high to moderate satisfaction with the level of their participation in the treatment process. A significant number of patients expressed a willingness for their family members to be informed about their illness, and more than half of them had moderate to high satisfaction with the information received from their doctors.

In addition, this study demonstrated a high tendency among patients to participate in the decision-making process. A high willingness to participate in medical decision-making has also been observed in other studies (17, 18).

Some studies have shown that the more patients estimate the severity of their illness, the more willing they are to participate in decision-making processes (19). Colomé et al., for instance, observed that the degree of patients' willingness to participate in the decision-making process is directly related to their perception of the severity of their disease. This was investigated by examining 115 volunteers in two scenarios: the first scenario involving breast cancer as a more severe disease and the second involving high blood pressure as a less severe disease. Colomé et al. found that participants in the breast cancer scenario were more inclined to participate in the treatment process compared to those in the hypertension scenario (19).

In another study, Cox et al. examined 473 patients and their doctors simultaneously and found that the more willing the patient was to participate, the more information the doctor provided, and the more the patient engaged in the treatment process (20). In our study, no significant relationship was found between patients' willingness to receive information and participate in decision-making and their perception of the severity of the disease. However, it was shown that the higher the patient's perception of the severity of their illness, the greater their estimate of participation in treatment decisions and their satisfaction with the information received.

The effect of factors such as age, sex, and education on patients' willingness to receive information and make decisions has been investigated in several studies. The results of this study show that women are more willing to participate in their treatment process than men. This result is consistent with the findings of other studies conducted in this field (13). According to these studies, compared to men, women tend to have more interaction power and are more willing to participate in their treatment process (13). Additionally, some studies have shown that there is a direct relationship between the level of education of patients and their desire for awareness and active participation in treatment. This means that with an increase in the level of education, the willingness to participate also increases (18, 27). Asghari's study, the only study conducted in Iran on this topic, confirms the direct relationship between these two parameters (13).

The inconsistency between the results of our study and those of similar studies can be explained through the linear regression analysis performed between the age and education levels of the patients in this study. In our study, the desire to receive information increased with age. Therefore, the level of education was significantly influenced by age differences. According to our findings, individuals with higher education levels were less willing to receive information related to their condition, and a higher percentage preferred to entrust all treatment decisions to their doctor, relying on the scientific expertise and skills of the treating physician. The deep-rooted paternalistic culture in the doctor-patient relationship in Isfahan, influenced by the adherence of the city's residents to traditional customs and practices, may explain the differences between the results of this study and those of other studies, including Asghari et al.'s study conducted in Tehran. Additionally, the lower willingness of individuals with higher education to receive information and participate in treatment decisions may be attributed to the increasing specialization of scientific fields. As a result, individuals with higher education in society, acknowledging this trend, may prefer to leave health-related decision-making to the experts.

To determine whether gender affects patients' willingness to be informed and participate in the treatment process, our study showed that women's willingness to participate in decision-making was significantly higher than men's. These findings are consistent with previous studies (13). Several explanations have been proposed for this connection. It is suggested that men may not feel confident enough to challenge the healthcare system and tend to be more conservative than women in their interactions with healthcare providers. Women, on the other hand, may expect more benefits and respect from the healthcare system. Additionally, it has been suggested that men are less involved in managing their healthcare and prefer to leave such decisions to their doctors, while women tend to be more assertive and confident in making healthcare decisions (21, 22).

Some studies consider patients' access to sufficient medical information as a prerequisite for their active participation in decision-making (23). Our research showed that most people are inclined to receive clinical information, which is consistent with the results of previous studies (24–26). The high willingness of patients to receive medical information and participate in decision-making contradicts the paternalistic view and supports the shared decision-making approach (23).

In examining patient satisfaction with participation in the decision-making process, this study showed that more than half of the participating patients were highly satisfied with their involvement in medical decision-making, which aligns with the findings of Asghari et al.'s study (13).

Our study also showed that married individuals were more satisfied with their participation in decision-making than single patients. Regarding the relationship between marriage and satisfaction with participation in decision-making, it is reasonable to note that the family serves as a social support unit and can play a significant role in encouraging patients to receive information and engage in the decision-making process during treatment. As a result, married patients tend to have higher expectations of their involvement and feel more satisfied with it (28).

It also showed that the level of satisfaction with participation in decision-making was higher in patients hospitalized in private hospitals compared to those in educational and governmental hospitals. Satisfaction with participation in the decision-making process may vary based on patients' willingness to be involved, their understanding of how participation works, and their ability to comprehend the information provided by the healthcare team (29). As a matter of fact, physicians in educational hospitals are generally able to provide patients with less medical information and involve them less in the decision-making process than in private hospitals. This is due to the higher workload of doctors, the necessity of dedicating time to teaching students, and possibly the lower average socio-economic level of the patients. These factors can likely explain the higher patient satisfaction with participation in decision-making in private hospitals.

This study also revealed that the level of patients' participation in decision-making has a significant positive relationship with the level of satisfaction with participation in decision-making. This finding was also observed in studies by Birkeland et al. They studied 24,000 Danish patients and used an online questionnaire to investigate the hypothesis that greater patient participation is associated with greater satisfaction. These researchers stated that if a patient's participation in the decision-making process is greater, even if an incurable malignancy develops in the future, the patient's satisfaction will still be higher than if they do not participate (30).

The results of this study showed that the patients' willingness to inform their companions about the disease was statistically higher in patients hospitalized in educational hospitals compared to those hospitalized in private hospitals. Studies have shown that the patients' perception of receiving health services in private hospitals is significantly higher than that in public hospitals (31). In addition, patient satisfaction with the hospitalization process in private hospitals was significantly higher (32). Due to the probable lower satisfaction of patients with the services of public hospitals, these patients might feel a greater need for support from their families during hospitalization to compensate for this lack of satisfaction.

Additionally, based on the findings of our study, the willingness of patients with more than 6 years of education to share clinical information with their companions was significantly lower than that of other patients. This finding aligns with a study by Alden et al., which was conducted on people from seven different countries. According to Alden's study, patients who feel more independent in relation to others are less likely to involve their companions in the decision-making process related to their treatment (18). In the context of our study, if we consider education as a factor for feeling independent, it is reasonable to suggest that patients with higher education are less inclined to inform their companions of their health status.

According to the results of this study, although patients had a strong desire to inform their companions about their illness, the companions' willingness to inform patients about their clinical condition was comparatively lower. This observation aligns with the findings of Sharma et al. (33). This finding can be explained by the family-oriented culture in Iran and the significant role of human emotions in decision-making within the country. However, given the high desire of patients to receive clinical information and the lower willingness of companions to share such information, it is crucial to emphasize that if doctors deliver clinical information to patients based on companions' preferences, the information received by patients may fall short of their own expectations, thereby contradicting the principles of patient-centered care.

It is worth mentioning that in some regions of Iran, despite the inclusion of medical ethics in medical school curricula, the doctor-patient communication model remains predominantly paternalistic. One of the key strengths of this study is its demonstration that patients in Iran are increasingly aware of their rights, including the right to autonomy, and are willing to exercise these rights in their treatment process. This growing awareness underscores the responsibility of physicians to create a conducive environment for patients' active participation in their treatment. Additionally, it highlights the need for policymakers and medical education planners to prioritize teaching the principles and standards of professional ethics, including respect for patients' autonomy.

Our study had several limitations. Patients who declined participation due to psychological conditions were excluded, potentially overlooking the perspectives of individuals with mental health challenges and lower satisfaction levels. Additionally, this study included only inpatients, leaving the opinions of outpatients unaddressed. Moreover, as the concepts of receiving information and participating in treatment decisions are relatively new and culturally dependent in our country, generalizing these findings requires conducting similar studies across different regions and among patients with diverse ethnic backgrounds.

It is recommended that the study be replicated in other regions of the country to facilitate a more comprehensive assessment of patients' willingness to receive information and participate in treatment decisions across Iran.

Conclusion

The findings of this study indicated that patients generally exhibited a relatively high inclination to receive information about their disease and participate in medical decision-making. This inclination was more pronounced among women, married individuals, and patients hospitalized in private hospitals compared to men, single individuals, and patients in public hospitals. Additionally, the results revealed an inverse relationship between the willingness to be informed and the level of education. Furthermore, patients' estimation of their participation in decision-making was positively correlated with their satisfaction with participation and their perception of the severity of their illness. It was also demonstrated that patients exhibited a greater desire to inform their companions about their clinical condition compared to the companions' willingness to inform the patients about their existing conditions. Consequently, doctors should prioritize direct and transparent communication with patients to accurately ascertain their genuine preferences regarding the receipt of information about their medical condition.

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Conflict of interest

There is no conflict of interest in this study.

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