Factors That Influence an HIV Coinfected Patient's Decision to Start Hepatitis C Treatment

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Abstract

Liver disease is a leading cause of morbidity and mortality among patients coinfecting with HIV and hepatitis C (HCV), yet few HIV coinfecting patients actually receive HCV treatment. Providers must first be willing to prescribe treatment, but the patient ultimately makes the decision to accept or decline a treatment recommendation. We used a process model framework to explore the factors influencing patients' treatment decision-making. We conducted semistructured interviews with 35 HIV coinfecting patients and 11 primary care providers at three HIV clinics in Los Angeles, California. Patients reported that stability of HIV disease, perceived need for HCV treatment, treatment readiness, willingness to deal with side effects, absence of substance abuse, and stability of mental health and overall life circumstances are key factors influencing treatment decision-making. Patients also spoke of the influence of the trusting relationship that many had with their provider, and providers acknowledged an awareness of the influence of how they present the risks and benefits of HCV treatment and the overall tone of their recommendation (encouraging, dissuasive, or neutral). These results speak to a social decision-making process between the patient and provider—a partnership that involves sequential interactions whereby both the patient and provider may influence the other's evaluation of the patient's readiness for treatment, with treatment initiation dependent on both agreeing on the need for treatment and the patient's readiness for treatment.

Introduction

NEARLY 30% OF HIV-POSITIVE AMERICANS are coinfecting with hepatitis C (HCV) including 70%–80% of injection drug users (IDUs),¹ and HCV-related liver disease is a leading cause of death in this population.^{2,3} Yet studies consistently show that less than one third of HIV coinfecting patients in the United States are deemed eligible for HCV treatment, and less than 10% actually receive treatment.^{4–9} Upon detection of HCV infection, for treatment to be provided, providers must first consider a patient an appropriate treatment candidate, and multiple medical and psychosocial factors can contribute to a provider's reluctance to recommend or offer treatment to a patient.^{10,11} Once treatment is offered, the decision to initiate or defer treatment is ultimately made by the patient once treatment is recommended, and 15%–30% of coinfecting patients decline treatment.^{5–7} Clearly, many patients perceive the risks of treatment to outweigh its benefits, though few

studies have examined specifically how coinfecting patients make HCV treatment decisions.

A patient's willingness to undergo HCV treatment is likely influenced by how the patient views the efficacy and burden or risk of treatment. Standard HCV treatment, which consists of 48 weeks of weekly pegylated interferon (PEG-IFN) injections in combination with daily ribavirin (RBV),¹² has demonstrated a success rate of 30%–45% among HIV coinfecting patients across all genotypes,^{13–15} but only 17%–29% among HIV patients with the predominant HCV genotype, namely genotype 1. Furthermore, HCV treatment is widely considered by the field to be highly toxic with common side effects that include flu-like symptoms, fatigue, depression and hematologic abnormalities, which lead many patients to prematurely discontinue treatment.^{4,16–19} Not surprisingly, a general fear and apprehension regarding side effects and their impact on quality of life and functioning are common among patients considering treatment.^{20–22} Despite these side effects

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and related patient concerns, some recommend early treatment for coinfecting patients to prevent more serious disease development.²³

Several psychosocial factors may also contribute to a patient's treatment decisions. Active psychiatric problems and substance abuse are commonly viewed by providers as contraindications to treatment,^{5,6} in part because substance use can worsen liver disease²⁴ and treatment side effects can result in psychiatric deterioration and relapse into drug use.^{25,26} The emphasis that providers place on mental health stability and abstinence from substance use may subsequently increase the self-awareness of patients with regard to their psychosocial readiness for treatment.²⁷ Social support and the treatment attitudes of key members of the patient's social network may also influence a patient's decision to accept or decline treatment.²⁸ Knowing others who have been on treatment, and their experience with treatment outcomes and side effects, can influence whether a patient decides to accept or refuse treatment.²² The doctor-patient relationship, the level of trust in one's doctor, and provider attitudes toward the cost-benefit ratio of HCV treatment may also impact a patient's decision to undergo treatment, although only few published studies have explored these relationships.²⁹

To explore the HCV treatment decision-making process of HIV coinfecting patients, we conducted a qualitative study of HCV treatment decision-making in which both providers and patients were administered semistructured interviews. In this article, we focus on factors influencing patients' treatment decision-making and the barriers to treatment uptake.

Methods

Study design

We used a process model framework and semistructured interviews to explore the process of HCV treatment decision-making among HIV coinfecting patients offered treatment. Our process model makes two types of assumptions. First, it assumes that the decision to start HCV treatment is one that is not instantaneous but rather unfolds over time and social space, and involves conversations with clinicians, staff, partners, family and other members of patient's social networks.³⁰ Second, the model assumes that such a decision is made under considerable uncertainty³¹ and to deal with such uncertainty, patients will undergo a cognitive process by which they simplify the decision-making task over time. For example, patients typically are uncertain about: (1) the risks and benefits of getting or not getting the treatment; (2) the costs in terms of time, resources, and side effects while on the treatment; and (3) the advantages and disadvantages of starting or delaying treatment. To address this uncertainty, patients often begin by identifying and prioritizing what they see as the core factors (often in conversations with others) and use these to make a final choice.

In the analysis for this article, we were primarily interested in these core factors that influence a patient's decision to accept or deny HCV treatment once treatment was offered or recommended by their provider. Separate provider interviews focused on the provider treatment decision-making process, the findings from which are reported elsewhere;³⁵ however, we also asked providers to share their thoughts on how the provider-patient relationship influences the patient's

treatment decisions and findings from that portion of the provider interview are reported in this article.

Sample

Patients. A total of 35 patients coinfecting with HIV and HCV were recruited from three HIV clinics located in Los Angeles County. Semistructured interviews were conducted over a 4-week period at each site in the summer of 2008. In an effort to examine factors influencing a range of HCV treatment decisions, we sought to interview patients who had been offered treatment ($n = 26$) as well as those who had not ($n = 9$), and among patients who had been offered treatment, those who had started treatment ($n = 17$) as well as those who declined treatment ($n = 9$). The site coordinator at each clinic (a clinic staff member) identified a convenience sample of coinfecting patients who represented these various treatment decision points and informed the patient of the study to assess their interest in participating. Patients who expressed interest were then referred to the study interviewer who confirmed eligibility, conducted written informed consent, and interviewed the patient individually. All procedures were approved by the Institutional Review Boards at RAND and each of the study clinics.

Providers. A total of 11 primary care providers from the three study clinics were administered semistructured interviews. These providers were the primary decision makers with regard to whether or not HCV treatment was recommended to patients. As part of these interviews, providers were asked about how their relationships with patients influenced the patient's decision to accept or refuse HCV treatment.

Semistructured interviews

Patient interviews were divided into three major sections: background information including demographics, specifics related to HIV and HCV diagnosis, and alcohol and drug use history; general impressions of issues related to HCV, including liver biopsies and treatment; and for those who had been recommended treatment, the factors influencing the decision of whether or not to undergo HCV treatment. The latter section (factors influencing treatment decisions) included a general inquiry about influential factors followed by specific probes related to the influence of the patient's HIV and HCV disease stages, substance use, the relationship with their doctor, and the influence of their social network. Structured interview guides were constructed to ensure that all key questions were asked and to permit comparisons within and across clinics. Open-ended questions preceded closed-ended questions to avoid biasing responses, to elicit unanticipated leads for further exploration, and to highlight areas of greatest significance to the respondents. Standard probes, such as verification and compare and contrast questions, were used to more fully elucidate specific content areas. All interviews were conducted by a research assistant, Dr. Wagner, or Dr. Osilla. The interviews were digitally recorded and transcribed verbatim. Patients were remunerated \$25 and providers were remunerated \$50 for the interview, except at one site where institutional regulations did not allow any payment to the providers.

Qualitative data analysis

Transcripts were reviewed to identify key themes; we identified text that involved processes, actions, assumptions, and consequences, repetitions across informants, and shifts in content with regard to the decision-making process. After separately examining portions of the transcripts, we reached consensus about which themes to examine in detail. We constructed a framework of major factors and components influencing decision-making, and developed a codebook using standard procedures and text management software (e.g., Atlas/ti) to mark instances in which each theme occurred in the interviews. For each theme, we examined the range, central tendency, and distribution, which allowed us to discover decision criteria, patterns and generalities related to the decision-making process within and across patient groups.

Results

Sample characteristics

Of the 35 patients, 31 (89%) were male, mean age was 49.8 years (standard deviation [SD] = 8.1), and 22 (63%) were non-Caucasian (12 Hispanic, 9 African American, 1 Asian). Patients reported being diagnosed with HIV between 1986 and 2005. All but two were currently on HIV antiretroviral therapy, and the mean self-reported CD4 count was 470 (SD = 250; range: 93–1000). Timing of HCV diagnosis ranged from 2 to 18 years prior to the interview. The majority (27/35; 77%) had a history of alcohol or drug problems, with the latter including use of marijuana, cocaine, methamphetamine, and heroin. Over half (56%) reported past injection drug use. In terms of current substance use, 27% reported some alcohol use and 19% reported drug use (mostly marijuana).

Of the 35 patients, 26 patients reported being offered treatment for HCV and 9 reported not being offered treatment. These two subgroups were similar with regard to age and gender, but the group who had not been offered treatment had a higher proportion of African Americans (33% versus 23%), active substance users (25% versus 17%), and lower mean CD4 count (346 versus 521). With the focus of the study being factors influencing treatment decisions, the remaining analyses are specific to the 26 patients that were offered treatment.

Patients offered treatment

Of the 26 patients who reported being offered treatment by clinicians, 17 accepted treatment and 9 declined. These two subgroups were similar with regard to race/ethnicity, age, gender, current substance use, past injection drug use, and CD4 count. All 4 patients from site B who were offered treatment decided to start treatment, compared to 80% (8/10) of patients at site C and 42% (5/12) of those from site A. While we had tried to identify and interview patients who had refused treatment at all three study sites, site B was unable to identify any such patients. Of the 17 patients who had been on treatment, 8 completed treatment, 7 were currently on treatment, and 2 had prematurely stopped treatment.

Factors influencing a patient's decision to start or refuse treatment

Patients reported a range of factors that influenced their decision of whether to accept or refuse treatment in response

to their provider's offer to prescribe treatment. Factors related to wanting to refuse treatment included hope for better medications, not being psychologically ready, and not wanting to get sick when feeling well. Factors related to wanting to start treatment ranged from not wanting to waste time and the hope of being cured and being healthy, to feeling like there was nothing to lose by going on treatment, and a sense of trust and faith that their doctor would help them be successful with treatment. The most common factors across both groups of patients were perceived need to preserve physical health and survival, trust in the quality of relationship with one's provider, level of support for treatment within one's social network, and self-perception of treatment readiness.

Need for treatment to preserve physical health and survival. The most common reason patients reported for deciding to start treatment was concern over the effects of HCV disease on their physical health and related motivation to live and remain healthy, which was reported by 8 of the 17 patients (47%) who started treatment. For example, one patient currently in treatment stated:

First [priority] is to take care of myself. I was worried if I let this sickness continue into my body, maybe in the future it's going to be bad to my health and my person. This was why I was in a hurry to take this treatment.

Another patient who was motivated by his health to start treatment stated, "You have a choice. If I wanted to remain healthy and I wanted to continue having a productive, positive life, even with the HIV, this was something necessary. I had to do this." Another patient stated no hesitation related to his decision to start treatment, "As long as it's good quality of life, I mean, it was a no-brainer to me." Patients also spoke of nothing to lose when considering the potential benefits of treatment for their health, as exemplified by the following remark:

Because I feel like I don't have nothing to lose. The only thing I have to do is try it. Hopefully it will work. But if it doesn't work and the Hep C is still there, if I don't treat it, it's still there. If I treat it and it works well, it's gone as a result.

Treatment readiness. One factor that strongly influenced decisions to start treatment as well as to defer treatment was a sense of personal readiness for treatment. How patients viewed or defined their readiness for treatment varied considerably. For some patients, feeling that their HIV disease was under control and stable implied a readiness to then take on HCV disease, as exemplified by the following statement:

This sounds strange but—my HIV thing, I'm very optimistic. I mean, I have gotten through that program. I feel great. My numbers are always good. Always good. One day I'm in the car with my friend and I said, "You know, I'm not gonna die of AIDS; I'm gonna die of liver problems, . . . And I need to do something about that." I think that was the day I made the decision.

Others spoke of treatment readiness with regard to feeling ready to tolerate side effects, and being medically and psychologically stable. All patients were aware of the side effects that are common with HCV treatment, and several patients spoke of the need to be ready to tolerate and handle the potential side effects if they were to start treatment. Seven of the 17 (41%) patients who decided to start treatment expressed a

confidence in being able to handle treatment side effects compared to only one of nine (11%) patients who refused treatment. The concerns related to treatment side effects among patients who declined treatment is exemplified by a patient who explained his decision as a function of his fear of the side effects and the impact on his quality of life:

Why am I going to go and make myself sick when I don't feel sick right now? It was just like when I first started taking the HIV meds. I couldn't understand. I wouldn't wish that on my worst enemy. It was like self-inflicting yourself with the flu three times a day. That's how it was. I was sicker than a dog. If this treatment is going to do that to me, I don't want to have any part of it.

For many patients, treatment readiness was viewed in reference to a sense of stability in one's life—from feeling stable mentally and emotionally, to having substance use under control, and having a roof over one's head and being able to support oneself. Patients understood that treatment was going to be stressful and therefore they felt the need for more stability in their lives before starting treatment. One patient cited a need for more stable housing as contributing to his decision to defer treatment, "I want to be a little more stable in my life. Right now I'm in Sober Living. I would rather be in my own place, you know, so that I don't have to be around other people and have stress." One patient reported not wanting to pursue treatment because he was hopeless about his life. He stated, "I see no point in it. I see no point in prolonging a life that is not worth prolonging." This particular patient stated that his health has progressively deteriorated over time, "Every time I've done something for the better, two things got worse." One patient who had struggled with depression in the past was concerned that treatment side effects would lead to a relapse in his depression:

I have fears that if I go on this treatment and I start feeling sick for half a year or something like that, it may just drag me down so low that I won't be able to come back up and get where I'm at again. I know there's a chance that I could even be better, but something within me says don't go there.

Another patient stated he had considered his drug use when making his decision about treatment, and ultimately opted to defer treatment because he was not "sober enough":

Actually, she kind of told me, "You'd be a good candidate for treatment." And asked if I would like to. And I told her not right now because I'm not sober enough. I haven't got the time. Basically it's me waiting to be more sober. Yeah, if you're going to be able to get any kind of results out of it you've got to stop drinking.

Social support. While most patients expressed intrinsic reasons for wanting to start or defer treatment, several patients also referred to the influence of people in their social network.

Six of 17 patients (35%) who decided to start treatment stated that the HCV support group they attended was influential in their decision; HCV support groups were not mentioned at all by those who refused treatment, although it is not known whether these patients were members of such groups. Patients reported consulting with fellow patients about their experiences with treatment, including how they dealt with side effects and whether they viewed treatment as "worth it."

Being able to address their fear of side effects with a patient actually in treatment or who had recently completed treatment helped dispel misunderstandings about the treatment:

But then I did reach out to somebody. I did talk to somebody regarding the treatment. And that's why I came back. They'd been on treatment. They went through it, and they had hard times but he made it through. He said right now he's cured.

Doctor-patient relationship. When asked about the influence of the relationship with their doctor, 11 of the 17 (65%) patients who decided to start treatment reported that having a supportive doctor contributed to their decision compared to 2 of the 9 (22%) patients who refused treatment. While all patients in the study spoke favorably of their providers, it was the patients who decided to start treatment who often made especially strong statements about the quality of relationship they had with their doctor. One patient who had started and completed treatment stated, "I'm looking forward to my visits. 'Oh good! I get to see [my provider] today' . . . I think it was the most important thing, because any problem that I had . . . they just watched me every step of the way." Two other patients who had started and completed treatment emphasized the trust they had with their provider:

All I got to do here is do what's suggested by the doctors. And that's how I've kind of been approaching it. When they say try to do this or do that I try to do it to the best of my ability. Yeah. You know, I got complete trust in the doctors here and it was, kind of, like a no-brainer. They said, "We want to put you on it." It wasn't right after I was diagnosed. It was, kind of, like later on when they seen the virus going up, so they said,

"Maybe it's time for you to be on therapy." So I just went on it. It's a trust between you and your doctor. I think in a way I trust her because I can see she cares. It's not like just file and file and file. I ask her questions; she answers me. It was easy.

When discussing how their doctors were supportive, patients referred to how their providers were responsive, dependable, and provided hope and encouragement regarding benefits that could be derived from treatment. For example, a patient stated, "I mean I knew who to call. I had the numbers, and I have never waited more than a few hours to get a call-back." One patient who had started treatment stated, "Those guys (his doctors) had said, 'You can get rid of this.' I said, 'Well let's go for it. I'm all for it.'"

Provider presentation of treatment recommendation

With providers having an apparent strong influence on the patients' treatment decisions, the attitudes that providers have toward treatment and how they present treatment recommendations may play a key role in the patient's response. A number of providers acknowledged an awareness of the potential influence of how providers present treatment recommendations. As one provider put it, "Basically, you can tell by the way I'm talking about it, and the way physicians talk to patients, I can influence a decision by the way I'm presenting the data."

How providers present treatment recommendations to patients can vary from one that reflects strong advocacy and encouragement of treatment, to one that is more neutral and mere presentation of options, to a presentation that may subtly dissuade a patient from considering treatment. In

many cases, the provider's general philosophy and sense of urgency toward treatment was reflected in their approach to presenting treatment as an option for the patient.

The following quotes highlight the strategies some providers use to encourage and motivate patients to accept the treatment recommendation, including emphasizing the importance of treatment for the patient's health, the chance for treatment resulting in a cure, and confidence that the provider can effectively address any side effects that the patient may experience.

I usually tell patients that I can help manage most side effects. I explain that how you are going to perceive the treatment will affect your tolerability of therapy. I clarify the side effects they should expect like fatigue, myalgias, etc. I do tell them that these side effects are manageable, and this is how we treat them. I feel that once patients know what to expect, they do very well with treatment. I have not had a single patient drop out because of unbearable side effects.

We know that interferon ribavirin has a crummy response rate in genotype 1. We tell them that, but we say there's a chance we could cure you. And when you're cured, you're cured. I mean, I know that it's about one third of the people that we treat with HIV and Hep C will be cured. But I always tell them you could be that one in three.

Like several of the patients, the providers also referred to the importance of trust between the doctor and patient and its influence on the patient's decision process. One provider, who also adopted a more aggressive, urgent view of the need for treatment, spoke of the trust and bond that develops between the provider and patient, and how this can help the patient to accept the recommendation to start treatment.

I think that patients are only going to undertake difficult courses of action if they believe that there's merit there to get to that place. Many of the patients rely upon the credibility of their physician, so the establishment of trust. People only do things that they believe in. They only listen to people who they trust. So it's by establishing a real commitment to patient well-being and clear and direct communication with patients to follow through, and I believe it's very important to establish that.

Other providers described a more neutral stance in presenting treatment as an option to the patient. These providers described an approach in which they lay out the potential benefits and costs of treatment, so that the patient can make an informed decision. Providers may be more likely to use this approach when they themselves feel ambivalent or unsure of the importance of treatment for the patient.

Just a frank discussion with the patient and trying to let the patient make an informed decision for themselves as much as possible. Providing them with all the information. "Look, these are the odds of you getting cured. These are the potential side effects; these are the potential benefits if you do get cured." Almost putting it out on the table and letting the patient make an informed decision. In a case where there's a fairly clear cut yes or no, I think a lot of times you can present that opinion to the patient and say these are the multiple reasons why yes, these are the multiple reasons why no. I think they'll accept it. But when there's really that gray area when you really are on the fence, really, really, really trying to make it the patient's decision rather than your decision is the way to go.

There are also providers who took a more cautious view of treatment. These providers viewed treatment as urgent for some patients with advanced disease, but for many patients

with less progressed disease they believed it was best to defer treatment and wait for better treatment to become available, and this preference can be detected in how they offer treatment to the patient.

I might feel inclined to say, "Look, if you're anxious to be treated, let's do it, okay. We will know by week 12 whether you're likely to benefit from going on or not. So we could do that. On the other hand, we are reasonably certain, based on our tests, including a biopsy, that you don't have any significant fibrosis at this point, so that if you chose to, we think at maximum 4 or 5 years, there will be a very good or maybe a couple of good agents around that we would combine with interferon, plus or minus ribavirin. So you may want to have us watch and wait and talk about it in the next year or so."

I tell them, "You have HCV. This is long-term, it's not an emergency, but we'd like to discuss treatment with you." When we tell them about the treatment, the injectable nature of it and the side effect profile—it makes them not want to discuss it further.

Discussion

This study is among the few to investigate the decision-making process related to HCV treatment among HIV coinfecting patients, a population in which liver disease is a leading cause of morbidity and mortality. Factors that weighed prominently for patients in their decision-making process included their perception of the need for HCV treatment and the impact of liver disease on their health and survival, and being ready for treatment. Facets of treatment readiness included having a stable HIV disease and being mentally and emotionally ready to endure treatment side effects with the help of social support and stable overall life circumstances. Fear of treatment side effects and being uncertain of one's emotional stability and drug use were all concerns to patients who chose to refuse treatment. In contrast, patients who decided to start treatment indicated that confidence in being able to tolerate side effects was a key indicator of treatment readiness, as was having stable mental health and substance use under control. These findings are consistent with studies that show greater patient interest in HCV treatment is associated with higher readiness to change drug use, lower alcohol and drug abuse, and greater perceived need for treatment.^{29,32-34} Furthermore, these factors, namely HIV stability and treatment readiness, are strikingly similar to those reported in our examination of provider HCV treatment decision-making,³⁵ and speak to a parallel process between providers and patients with regard to HCV treatment decision-making.

Indeed, the study interviews revealed a prominent role for the doctor-patient relationship in patient decisions regarding HCV treatment. Little is known about the influence of providers' HCV treatment attitudes and the provider-patient relationship on patients' treatment decision making. These doctor-patient relationship variables may be particularly important among ethnic minorities where there are cultural differences in attitudes toward the medical establishment,³⁶ especially in the context of a highly toxic treatment. Also, drug users often struggle with low self-esteem and disempowerment, which can result in passivity toward treatment seeking and participation in medical decisions.³⁷ Mistrust in providers and treatment recommendations was not reported by the patients in our study; rather, strong doctor-patient

relationships and a high degree of trust in one's provider played an important role in patient treatment decisions, particularly among patients who decided to start treatment. While all patients spoke positively of their doctor, it was the patients who opted for treatment who made noted references to the trust they had in their provider and their treatment recommendations. Several patients stated that a recommendation from their provider to start treatment was all they needed to make their decision. These patients spoke of their provider as not only trustworthy, but also reliable, responsive, caring and encouraging of hope regarding the potential benefits of treatment.

It is clear that providers play an important role in the patient's decision process; particularly how they framed their treatment recommendation. Patients consider the risks and benefits when evaluating their need and motivation for treatment³⁸; therefore, how providers present the possible costs (side effects) and benefits (cure, improved liver function), and whether they use an encouraging, dissuasive, or neutral approach to presenting treatment can play a critical role. HCV treatment is toxic and has limited efficacy, yet still offers the potential for a cure; hence, some providers view treatment as urgent and encourage patients to start treatment, while other providers view treatment more cautiously and advise patients that treatment can often be delayed in hopes for more effective treatment options in the near future. As we reported previously, the sites differed with regard to provider attitudes toward the urgency of HCV treatment for HIV coinfecting patients,³⁵ and it was the sites with providers who had a more urgent view of treatment who reported higher HCV treatment rates and had a higher proportion of patient participants in this study who decided to start treatment.

The similarity in the factors reported by both patients and providers as being influential in their decision-making process, and the impact of the provider-patient relationship, suggests the presence of a social decision-making process. Treatment decisions do not just involve an evaluation of a list of potential costs and benefits, but an interactive process between providers and patients who are partners in the management of the patient's health. Ultimately, for treatment initiation to be a viable option, both the patient and provider must agree on the need for treatment and the patient's readiness for treatment. Achieving this agreement involves a sequence of interactions between the provider and patient and an iterative process that involves mutual feedback loops by which both the provider and patient influences the other's opinions until a consensus is reached about the appropriateness of treatment for the patient.

This study has a number of limitations. The study was not designed to be representative or generalizable to all coinfecting patients and their providers. The small sample size was not randomly selected, but purposively selected to provide the full range of provider and patient experiences and decisions. Participants were selected by providers; hence, these patients might tend to have a stronger bond or relationship with their provider, compared to the overall population of coinfecting patients. Furthermore, the participating sites may not be representative of most HIV clinics in the United States, as HCV treatment rates for HIV coinfecting patients were considerably higher at two of the three sites compared to what has been published in the literature. However, with the clin-

ical community moving toward a more aggressive approach to HCV clinical management, the experiences of the patients and providers at the study sites may reflect the future trends in community practice.

In conclusion, the patients in this study confirmed what had been reported by their providers, that stability of HIV disease, perceived need for HCV treatment, and treatment readiness with regard to motivation, preparedness to deal with side effects, absence of substance abuse, and stability of mental health and overall life circumstances are key factors influencing treatment decision-making. Providers play a critical role in the treatment decisions of their patients, not only by providing information and being trustworthy experts, but also through their partnership with the patient and the sequential interactions whereby both the patient and provider may influence the other's evaluation of the patient's readiness for treatment. Providers serve as key catalysts for evaluating treatment readiness, but also helping patients to address issues that impede readiness, whether through referrals, counseling, or simply ongoing support that fosters the patient's trust. These results highlight not only the need for effective screening tools to assess perceived need for treatment and the multiple components of treatment readiness, but also methods for further examining this social treatment decision-making process between patients and providers.

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