

The relative importance of patients' decisional control preferences and experiences

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Objective: Patients' role in treatment decision-making can influence psychosocial and health-related outcomes (i.e. satisfaction, felt respect, adherence). We examined decisional control in a surgical context, identifying correlates of patients' preferences and experiences.

Design: 380 patients and 7 surgeons were surveyed during initial surgical consultation visits in a low-income outpatient clinic.

Measures: Patients reported preferences for (pre-consultation) and experiences of (post-consultation) decisional control, demographics, satisfaction with care, and adherence to treatment recommendations. Surgeons rated patients' health status.

Results: Preferences for and experiences of decisional control were unrelated, suggesting significant preference–experience misalignment. However, this misalignment did not appear to be consequential for patient outcomes. Rather, more decisional control, regardless of patients' preferences, predicted greater satisfaction with care and greater self-reported adherence as assessed at a post-surgical appointment.

Conclusions: Decisional control predicts better outcomes for patients, regardless of their preferences for control over treatment decisions. These findings suggest that interventions should aim to increase patients' degree of decisional control when feasible and appropriate.

Keywords: decisional control; surgical communication; patient satisfaction; shared decision-making

Introduction

Shared decision-making models of patient care are characterised by an equal exchange of information between the patient and healthcare provider and are intended to promote patient autonomy and empowerment. In this model, physicians encourage patients to deliberate on and express preferences for treatment, and they collaborate to make final decisions about treatment (Charles, Gafni, & Whelan, 1999; Charles, Whelan, Ghafni, Willan, & Farrell, 2003). Patients' ability to play an active role in making decisions about their treatment is referred to as decisional control (Adams & Drake, 2006). Decisional control and models of shared decision-making share conceptual underpinnings, but decisional control refers to patients' specific role in a treatment decision process

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rather than a broad approach to healthcare (Edwards & Elwyn, 2006). To avoid ambiguity, we note that the current study focused on decisional control, not shared decision-making more broadly. Specifically, the current study examined the role of patients' preferences for and experiences of decisional control in predicting two key outcomes: satisfaction with care and adherence to treatment recommendations.

Benefits of decisional control

Active participation in decision-making has many benefits for patients. Patients actively involved in treatment decision-making are better at coping with negative decision-related emotions (e.g. anxiety, distress), especially when the treatment options involve clear and significant trade-offs (Luce, 2005). Furthermore, patients who perceive themselves as having an active role in their treatment receive more information during communication with their physicians and report greater functional ability (Greenfield, Kaplan, & Ware, 1985). Decisional control dynamics can also influence biomedical outcomes (Stewart, 1995). Patients who perceive a lack of control over their treatment report worse symptoms and poorer health compared to patients who feel a sense of control over their treatment (Seeman & Seeman, 1983). Patients who play an active role in their treatment also report greater satisfaction (Greenfield et al., 1985; Keating, Guadagnoli, Landrum, Borbas, & Weeks, 2002), whereas patients unsurprisingly become dissatisfied with their treatment when physicians fail to meet their expectations and preferences for control (Adams & Drake, 2006). Finally, decisional control has been linked to behavioural outcomes, such as switching to a new physician (Keating et al., 2002) and adherence to treatment recommendations (Ludman et al., 2003; Von Korff et al., 2003).

Dynamics of decisional control

Although the benefits of decisional control are well established, it remains unclear whether maximum control is optimal or if patients' degree of control should match their control preferences. In fact, patients' preferences for and experiences of decisional control vary greatly depending on personal characteristics (Katz et al., 2005; Levinson, Kao, Kuby, & Thisted, 2005; Say, Murtaugh, & Thompson, 2006) and situational variables (Beaver et al., 1996; Den-Brink et al., 2006; Rosen, Anell, & Hjortsberg, 2001), and one consequence of this variation is that patients' experiences with a particular treatment decision process may or may not align with their preferences for decisional control. Both patients and physicians contribute to discrepancies between patients' preferences and experiences of decisional control. Physicians often make assumptions about patients' preferences for decisional control (Légaré, Ratté, Gravel, & Graham, 2008), which may be inaccurate. Patients may also undermine their own authority during a medical interaction. Many patients who report a desire to play an active role in their treatment remain passive during medical interactions (Beisecker, 1988; Simonoff, Fetting, & Abeloff, 1989). Moreover, practical barriers to implementing shared decisional control (e.g. time constraints) serve as obstacles, even among doctors who advocate patient involvement (Gwyn & Elwyn, 1999). The tendency for patients and doctors to undermine patients' control is especially problematic in light of the aforementioned benefits of shared decision-making (Greenfield et al., 1985; Luce, 2005; Ludman et al., 2003; Seeman & Seeman, 1983; Stewart, 1995; Von Korff et al., 2003).

Given the barriers of miscommunication, passivity and time constraints, it is unsurprising that patients do not receive the degree of decisional control they desire. Although many studies have examined preferences or experiences of decisional control separately, fewer studies have examined preferences alongside experiences. Studies that have examined both preferences and experiences of decisional control in other healthcare contexts find mixed evidence for alignment between patients' preferences and experiences. Cross-sectional studies (i.e. studies that assess both preferences and experiences following the decision process) find that as few as 42% of patients report a match between their preferred role in decision-making and the role they played in actuality (Degner et al., 1997), whereas other cross-sectional studies report a preference–experience alignment rate as high as 70% (Larsson, Svardsudd, Wedel, & Saljo, 1989; Lantz et al., 2005; Murray, Pollack, White, & Lo, 2007; Vogel, Bengel, & Helmes, 2008; Wallberg, 2000) and others fell in between the two extremes (Bilodeau & Degner, 1996; Chapple, Shah, Caress, & Kay, 2003; Davidson, Brundage, & Feldman-Stewart, 1999; Ford, Schofield, & Hope, 2003; Keating et al., 2002; Ramfelt, Langius, Bjorvell, & Nordstrom, 2000; Turner, Maher, Young, Young, & Hudson, 1996). A meta-analysis of such studies concluded that approximately 60% of patients on average report alignment between their decisional control preferences and experiences (Kiesler & Auerbach, 2006; see also Tariman, Berry, Cochrane, Doorenbos, & Schepp, 2010).

Unfortunately, each of the studies just mentioned includes a critical limitation. Because patients reported their preference for decisional control following the treatment decision process, it is quite likely that the degree of decisional control they experienced (and perhaps other factors such as the success of treatment) influenced their reported preferences. In contrast, studies that assess patients' preferences prior to the decision process, and thus eliminate the possibility that experience influenced their report of decision preferences, are elusive. Two studies in particular provide a clear comparison between pre-consultation preferences and post-consultation reports of decisional control (Janz et al., 2004; Gattellari, Butow, & Tattersall, 2001) and found that 42 and 34% of patients reported a match between preferences and experiences, considerably fewer on average than reported in cross-sectional studies.

Study overview

The current study examined patients' preferences for and experiences of decisional control with a prospective design that allows a clear comparison between pre-consultation preferences and post-consultation reports of decisional control. This approach provides an appropriate comparison between preferences and experiences, as well as an opportunity to examine outcomes of decisional control as predicted by preferences, experiences or the degree of alignment between them. Regarding outcomes, we examined patients' satisfaction with their care and their self-reported adherence to treatment recommendations. Although several studies have examined the relationship between decisional control and satisfaction, considering both preferences for and experiences of control, these studies are nearly all cross-sectional in nature, and the two prospective studies mentioned earlier came to conflicting conclusions (Janz et al., 2004; Gattellari et al., 2001). No study we know of has examined the independent and joint roles of decisional control preferences and experiences on adherence, and as such our study adds a critical piece to the puzzle of decisional control outcomes.

We pitted two competing hypotheses against each other in our study. Due to the scarcity of prospective studies and the conflicting findings within the few that exist (Janz et al., 2004; Gattellari et al., 2001), it remains quite unclear whether decisional control is in itself beneficial (i.e. preferences are irrelevant) or if alignment between decisional control preferences and experiences is optimal. We anticipated that greater decisional control would generally predict greater satisfaction with care and more consistent adherence to treatment recommendations; however, we were relatively agnostic to the role of preferences or preference–experience alignment at the outset of the study. The current study also explored predictors of decisional control preferences and experiences, with a focus on patient characteristics (i.e. demographics, general health, severity of the patient’s condition) to provide a thorough sense of the dynamics of decisional control in our particular sample and healthcare context.

Two additional aspects of our study deserve note. First, studies of decisional control typically examine contexts in which patients have repeated interaction with physicians, as in the context of extended care (e.g. cancer) or primary care settings. Little is known about the nature and correlates of decisional control in the context of clinic-based consultations. Therefore, it is unclear whether the results from previous studies can be generalised to contexts in which continuity of care is limited or absent. The consultations examined in the present study were brief and isolated, with limited opportunity to build rapport between physicians and their patients.

Second, the current study examined preferences for and experiences of decisional control in the context of clinic-based surgical consultations using quick, easy to understand single-item measures specifically created for the context of clinic-based consultations. No standardised measure of decisional control captures both preferences and experiences of control (Ervin & Pierangeli, 2005), and validated measures assessing preferences and experiences separately require extensive and time-consuming participation from the patient (e.g. card sorting task, Hack, Degner, & Dyck, 1994; multi-item scales, Auerbach, 2001; Ervin & Pierangeli, 2005). Such measures are simply impractical in the context of busy, fast-paced and often fleeting interactions in a clinic setting. The authors acknowledge the richness of the construct of decisional control, which may be oversimplified by single-item measures; however, the measures used in this study (‘How much control do you want to have over the decisions about your healthcare?’ and ‘How much control do you feel like you have over the decisions about your treatment?’) are highly face valid and are sufficiently simple and brief to be effective for populations with literacy or educational limitations. A secondary goal of the present study was to validate these brief measures by examining their ability to predict patients’ perceptions of their consultation.

Method

Participants and recruitment

Participants were surgeons ($n = 7$; all male) and patients ($n = 380$; 51% female) recruited from the Riverside County Regional Medical Clinic (RCRMC) in Moreno Valley, CA. Patients were eligible for the study if they were between 18 and 90 years old ($M_{\text{age}} = 44.7$) and had a pre-surgical appointment at the general surgery clinic between November 2011 and December 2012. Materials were available in English and Spanish, the two

predominant languages of patients at the clinic. All participants provided informed consent prior to participation in the study. Approval for all procedures was obtained from the Institutional Review Boards at the University of California, Riverside and at RCRM.

Only a subset of this patient sample ($n = 143$, 35.3% retention) completed the follow-up questionnaire assessing adherence to treatment recommendations. Although we were unable to determine with certainty the reason for attrition in most cases, many patients left the study because they did not undergo surgery following the initial consultation ($n \approx 100$), others failed to return for their follow-up visit after surgery, and others declined participation at the follow-up due to pain, discomfort or time restrictions. We compared patients who returned at follow-up to patients who did not return and found no differences between the samples in terms of demographics, self-reported health or severity of condition, or decisional control preferences or experiences at the initial consultation. See Table 1 for full sample characteristics.

Procedures and measures

The data presented here were collected as part of a larger project examining communication in a surgical context. The goals of this paper are addressed by four questionnaires included in the study. Patients completed the first questionnaire prior to their consultation with the surgeon at a pre-surgical visit. After their consultation with the surgeon at this appointment, participants completed a second questionnaire. Surgeons also completed a brief post-consultation questionnaire at this appointment. Finally, patients who returned for a post-surgical follow-up appointment completed a follow-up questionnaire when they arrived for that visit.

Table 1. Patient sample characteristics.

Characteristics	Full patient sample ($n = 380$)	Follow-up sample ($n = 143$)
% Female	51%	55%
Mean age (SD)	44.7 (12.4)	44.7 (12.4)
Education	—	—
Did not complete high school	31%	36%
Completed high school only	53%	49%
Completed college	16%	15%
Health insurance	—	—
HMO/PPO	5%	5%
MediCal or MediCare	14%	18%
Local low-income programme	63%	66%
No coverage	18%	11%
Employed	31%	39%
Health literacy (1–10 scale)	7.1 (3.4)	7.1 (3.4)
Ethnicity: Hispanic/Latino	55%	60%
Race	—	—
White/Caucasian	85%	90%
Black/African-American	9%	6%
Asian	2%	<1%
American Indian/Alaska native	1%	<1%
Native Hawaiian/Pacific islander	<1%	<1%
Other	2%	2%

The initial pre-consultation questionnaire included a measure of patients' preferences for decisional control ('How much control do you want to have over the decisions about your healthcare?'; 1 = *no control*, 10 = *complete control*). Although the measures of decisional control preferences and experiences were adapted specifically for the purpose of this study, we would note that other researchers have successfully used single-item measures to assess decisional control (e.g. Arora & McHorney, 2000; Blanchard, LaBrecque, Ruckdeschel, & Blanchard, 1988). This questionnaire also assessed patients' emotional state (most relevant to this study, 'How sad do you feel right now?' 1 = *not at all*, 10 = *extremely*), health literacy ('How confident are you filling out medical forms by yourself?'; 1 = *not at all*, 10 = *completely*; $M = 7.15$, $SD = 3.6$; Chew, Bradley, & Boyko, 2004; Chew et al., 2008) and demographic information.

Following the initial surgical consultation, patients completed a second questionnaire prior to leaving the clinic that included a measure of the patient's experience of decisional control in the surgical consultation ('How much control do you feel like you have over the decisions about your treatment?'; 1 = *a little control*, 10 = *total control*). This questionnaire also assessed satisfaction with care (three items assessing satisfaction with the hospital, the surgeon seen that day and the consultation itself; Haskard et al., 2008; Tarlov et al., 1989; Cronbach's $\alpha = .71$) and adherence intentions ('How likely are you to do exactly what the doctor(s) you saw today suggested?'; 1 = *definitely not*, 10 = *definitely will*; DiMatteo et al., 1993). Only 346 of the 380 patients completed the second questionnaire due to time constraints that prompted some patients to leave before the research assistant could approach them again.

The attending surgeon also completed a brief questionnaire following the initial consultation, which included ratings of the patient's current health (1 = *extremely sick*, 7 = *extremely healthy*) and the severity of the patient's health condition (1 = *very mild*, 7 = *very severe*).

Finally, patients who participated at their initial consultation were identified if they returned for a post-surgical follow-up visit at the same clinic. These visits ideally occurred approximately two weeks after surgery, although in many cases patients took longer to return. The mean time between the initial pre-surgical consultation and the post-surgical follow-up was 49 days (median = 35 days). The follow-up questionnaire included the General Adherence Scale, a five-item self-report measure of adherence to treatment recommendations developed by DiMatteo et al. (1993). The items composing this scale are as follows: 'Thinking about the time since your surgery, did you have a hard time doing what the doctor suggested you do?' '... did you follow your doctor's suggestions exactly?' '... were you unable to do what was necessary to follow your doctor's treatment plans?' '... did you find it easy to do the things your doctor suggested you do?' and 'Generally speaking, how often were you able to do what the doctor told you?' (for all items, 1 = *none of the time*, 2 = *a little of the time*, 3 = *some of the time*, 4 = *a good bit of the time*, 5 = *most of the time*, 6 = *all of the time*). Upon calculating internal reliability, it became clear that patients' responses on the reverse-scored items ('I had a hard time ...' and 'I was unable to do what was necessary...') were unreliable (Cronbach's α for full scale = .36; see Tomás & Oliver, 1999 for discussion of similar issues with reverse-scored scale items). By removing these two items from the scale, the internal reliability of the remaining items rose to an acceptable level (Cronbach's $\alpha = .75$). We averaged patients' responses on these three items to form an adherence composite measure.

Analysis plan

To examine predictors of decisional control preferences and experiences, we conducted bivariate correlation analyses between patient characteristics and patients' ratings of preferences and experiences. For our primary analyses examining outcomes of decisional control, we conducted multiple regression procedures using the PROC REG procedure in SAS 9.3, which uses least-squares estimates to fit linear regression models. We tested separate models for satisfaction, adherence intentions and self-reported adherence, in each case predicting the outcome variable from patients' preference and experience ratings (each statistically controlling for the effect of the other). This approach allowed us to control for the relationship with one decisional control rating (preference or experience) while assessing the relationship between the other rating and the outcome variable.

Results

Descriptive analyses

Many patients' subjective experiences did not align with their preferences for decisional control. Participants preferred relatively high levels of decisional control on average ($M = 8.95$ out of 10, $SD = 2.15$). Similarly, participants also experienced high levels of decisional control on average ($M = 7.51$, $SD = 3.33$). However, participants' preferences were not significantly correlated with their experiences, $r(342) = .06$, $p = .27$, suggesting some degree of decisional control misalignment. Neither preferences for control, $F(6, 328) = 1.27$, $p = .27$, nor experiences of control, $F(6, 331) = 1.12$, $p = .35$, differed across the seven surgeons who saw patients in our study so we collapsed across surgeons for all analyses.

Predictors of decisional control preferences and experiences

Table 2 presents bivariate correlations between patient characteristics and decisional control preferences and experiences. Male patients and healthier patients preferred more decisional control, and patients with better health literacy received more control. No other patient characteristics were significantly correlated with decisional control preferences or experiences (see Table 3 for descriptive statistics).

Outcomes predicted by decisional control

Despite the clear incidence of decisional control misalignment in our sample, multiple regression analyses revealed little support for the importance of preference–experience alignment for patient outcomes and instead supported the broad benefits of decisional control experiences. In all cases, patients' reported experience of decisional control predicted their outcomes: satisfaction, $\beta = .51$, $p < .0001$; adherence intentions, $\beta = .48$, $p < .0001$; self-reported adherence at follow-up, $\beta = .21$, $p = .02$. In no case did preferences for decisional control predict outcomes: satisfaction, $\beta = .01$, $p = .92$; adherence intentions, $\beta = .06$, $p = .47$; self-reported adherence at follow-up, $\beta = -.06$, $p = .50$ (see Table 3 for detailed correlation information).

Table 2. Bivariate correlations with decisional control preferences and experiences.

	Decisional control preferences (<i>n</i> = 380)	Decisional control experiences (<i>n</i> = 342)
Age	-.07	.10
Gender	.14*	-.03
Education	-.06	-.06
Ethnicity	.06	.08
Health literacy	.09	.12*
Surgeon-rated health	.11*	.08
Surgeon-rated severity of condition	.07	-.03

Note: Gender coded 0 = female, 1 = male. Ethnicity coded 0 = not Hispanic, 1 = Hispanic.

* $p < .05$.

Table 3. Descriptive statistics and bivariate correlations among primary study variables.

	Decisional control preferences	Decisional control experiences	Satisfaction	Adherence intentions	Self- reported adherence
<i>Descriptive statistics, M (SD)</i>	8.95 (2.15)	7.51 (3.33)	8.85 (1.52)	8.99 (2.11)	4.21 (.96)
<i>Bivariate correlations</i>					
Decisional control preferences	–				
Decisional control experiences	.06 (<i>n</i> = 342)	–			
Satisfaction	.02 (<i>n</i> = 342)	.45* (<i>n</i> = 346)	–		
Adherence intentions	.08 (<i>n</i> = 342)	.31* (<i>n</i> = 346)	.36* (<i>n</i> = 346)	–	
Self-reported adherence	-.05 (<i>n</i> = 128)	.21* (<i>n</i> = 120)	.25* (<i>n</i> = 120)	.07 (<i>n</i> = 120)	–

* $p < .05$.

We sought to rule out two potential confounds. First, we repeated our multiple regression analyses controlling for surgeon ratings of patients' health and the severity of the health condition. In all cases, the relationship between patients' reported experience of decisional control and their outcomes remained significant: satisfaction, $\beta = .51$, $p < .0001$; adherence intentions, $\beta = .47$, $p < .0001$; self-reported adherence at follow-up, $\beta = .20$, $p = .02$. Second, we explored the possibility that patients' emotional state (e.g. mild depression) might explain both their reports of decisional control experiences and their outcomes. Although we did not assess depression per se, we used patients' self-reported sadness in the pre-consultation questionnaire as a proxy measure. Again, the relationship between patients' reported experience of decisional control and their outcomes remained significant, controlling for sadness: satisfaction, $\beta = .51$, $p < .0001$; adherence intentions, $\beta = .48$, $p < .0001$; self-reported adherence at follow-up, $\beta = .22$, $p = .02$.

Discussion and conclusion

Discussion

The goal of the current study was to examine the relative importance of patients' preferences for and experiences of decisional control for predicting satisfaction and adherence in a fast-paced and low-income clinical setting. Many patients in this study did not experience their preferred amount of decisional control. However, we found that misalignment between preferences and experiences did not appear to be related to patients' psychosocial responses to the surgical consultation (i.e. satisfaction, adherence intentions and adherence). Instead, we found that patients who reported experiencing more decisional control, regardless of their preferences, had better outcomes. Specifically, we found that patients who felt that they had more control over their treatment decisions were more satisfied with their care and had stronger adherence intentions than patients who perceived less control, as assessed immediately following the consultation.

The most novel and perhaps most compelling finding from the current study is that experiences of decisional control predicted patient-reported adherence to the surgeon's recommendations at a post-surgical follow-up visit. Based on patients' scores on the modified General Adherence Scale (DiMatteo et al., 1993), patients who received more decisional control considered it easier to follow their doctors' recommendations and reported engaging in more adherent health behaviours during the time since their surgery. This finding is particularly interesting given that the average length of time between patients' initial consultations and their post-surgical follow-up appointment was more than one month.

One potential explanation for these findings is that patients who felt that they were more involved in decisions about their treatment and care may have felt a greater sense of 'buy-in' to the treatment process as a whole. Relevant to this explanation is a large body of research on self-determination theory, which demonstrates the critical importance of three fundamental human needs: relatedness (closeness and connection to others), competence (a sense of efficacy) and, most relevant to our findings, autonomy (a sense of control over one's life; Deci & Ryan, 2008; Ryan & Deci, 2000). Consistent with our findings, interventions targeting patients' sense of autonomy have successfully increased rates of medication adherence (e.g. Ryan, Patrick, Deci, & Williams, 2008; Williams, Rodin, Ryan, Grolnick, & Deci, 1998). Our findings lend further support for the importance of autonomy and suggest that decisional control dynamics during even a brief consultation with a physician may set the tone for participants' overall sense of engagement in their treatment, which translates into a commitment and motivation to adhere to physicians' recommendations. Furthermore, it seems that patients who experience (or at least report) more control over their treatment decisions are more likely to adhere to recommendations, regardless of whether they preferred a high degree of control.

Thus, across all patient outcomes examined in our study, low decisional control is associated with particularly poor patient outcomes. Accordingly, our study suggests that patients' stated preferences for control may not serve as the best guideline for physicians to follow. In fact, based on these findings, physicians may want to err on the side of giving patients more control when the primary goal of the interaction is to maximise satisfaction or to motivate adherence to recommendations. These findings suggest that decisional control within patient–doctor communication may have served a persuasive

or motivational purpose in promoting health behaviour change. Of course, the potential consequences of providing too much decisional control to patients should be further examined with studies that use prospective designs and include outcomes beyond satisfaction and adherence (e.g. health outcomes, post-surgery recovery).

Limitations

The current study was limited in several ways. First, this particular study design did not afford causal conclusions. That is, although we refer to satisfaction and adherence as 'outcomes' of decisional control experiences, it is unclear whether the causal arrow points in the hypothesised direction. That is, it is possible that patients who were pre-disposed toward satisfaction and adherence elicited more decisional control from their physicians. Furthermore, the findings from this study rely on patients' self-reported responses to our questionnaires and are consequently tied to patients' subjective interpretations of decisional control experiences and their recollections of adherence behaviour. Randomised controlled trials may be able to provide clearer support for our conclusions.

Second, the means for patients' ratings of their preferences and experiences (8.95 and 7.51 out of 10 for preferences and experiences, respectively) suggest the potential for ceiling effects, although patients did provide a full range of responses on both items (i.e. from 1 to 10). Of course, a problematic restriction of range on either variable would drastically reduce the likelihood of finding significant relationships with other variables. Thus, we are confident that ceiling effects were relatively unproblematic with regard to decisional control experiences, which predicted satisfaction and adherence, but we are less confident about the role of ceiling effects with regard to decisional control preferences. Thus, our null findings for control preferences should be interpreted with a degree of caution.

Third, this inquiry was limited to a specific type of healthcare appointment: a surgical consultation. Patients in this study likely had undergone several phases of care for the relevant health condition before attending the clinic for their surgical consultation, and these visits might be characterised by different decisional control dynamics. Similarly, patients' conditions are subject to further change again after the initial medical consultation. Although the usefulness of 'thin-slices' (i.e. brief excerpts of an interaction) is well established (Ambady & Rosenthal, 1992), limiting the current inquiry to a single type of health care visit did not allow us to examine dynamic patterns of decisional control preferences over the full course of treatment.

Finally, this study is limited in that it only examines decisional control in the context of one clinic population. Similarly, although many patients are represented in the data, the surgeon sample is limited to seven participants. Future studies should examine decisional control preferences and experiences in contexts that afford the use of complex statistical procedures examining multiple levels of analyses to draw comparisons between different physicians and clinic populations. Nonetheless, this study provides novel insights as the first to prospectively examine decisional control, and particularly its relationship with adherence, in the unique and understudied context of fast-paced clinic consultations.

Conclusion

This study presents an important investigation into the interplay between patients' preferences and experiences of decisional control, in the context of a low-income clinic setting and using a design and measures appropriate for the research question and setting. This study is the first we know of to consider the unique relationships between patients' preferences and experiences of decisional control with self-reported adherence using a prospective design. The prospective design of this study allows for a clear comparison between pre-consultation preferences and post-consultation experiences, and thus the novel findings from this study make a significant contribution to the literature on decisional control. Specifically, we found that despite frequent reports of preference–experience misalignment in our sample, such misalignment was relatively unimportant with regard to patient outcomes. Rather, only the experience of decisional control was associated with satisfaction and, more importantly, adherence to physicians' recommendations.

The findings from this study suggest that patients benefit from taking part in their treatment decisions, or at least from having the sense that they were given an opportunity to participate. As such, both surgeons and patients must be vigilant in their role in conversations about treatment decisions to ensure that patients are engaged with the decision process at all stages. Despite numerous barriers (e.g. time restrictions, norms of passivity for patients), our findings suggest that physicians may nonetheless be wise to encourage patients' participation, with the ultimate goal of having happier, healthier patients.

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