Published in final edited form as:

Int Urogynecol J. 2010 September ; 21(9): 1071–1078. doi:10.1007/s00192-010-1155-8.

Treatment decision-making and information-seeking preferences in women with pelvic floor disorders

Vivian W. Sung,

The Division of Urogynecology and Reconstructive Pelvic Surgery, Department of Obstetrics and Gynecology, Women and Infants' Hospital/Warren Alpert Medical School at Brown University, 695 Eddy Street, Providence, RI 02903, USA

Christina A. Raker,

The Division of Research, Women and Infants Hospital, Providence, RI, USA

Deborah L. Myers, and

The Division of Urogynecology and Reconstructive Pelvic Surgery, Department of Obstetrics and Gynecology, Women and Infants' Hospital/Warren Alpert Medical School at Brown University, 695 Eddy Street, Providence, RI 02903, USA

Melissa A. Clark

Department of Obstetrics and Gynecology, Alpert Medical School at Brown University, Providence, RI, USA, Department of Community Health, Alpert Medical School at Brown University, Providence, RI, USA

Vivian W. Sung: vsung@wihri.org

Abstract

Introduction and hypothesis—The Autonomy Preference Index (API) and Control Preferences Scale (CPS) measure information-seeking and decision-making preferences. Our objective was to validate these scales in women with pelvic floor disorders (PFDs) and identify variables associated with decision-making preferences.

Methods—Women seeking care for PFDs completed the API and the CPS. Psychometric properties were determined. Multivariable analyses were used to identify correlates of information-seeking and decision-making preferences.

Results—One hundred ten women were recruited. Both scales demonstrated good psychometric properties (intraclass correlation coefficient=0.5 to 0.7; Cronbach's alpha = 0.8 for the API, and $r = -0.3$ between the API and CPS). Based on scores, women had strong preferences to be well informed, but were more neutral in their decision-making preferences. In multivariable analyses, higher education levels were associated with a stronger desire for seeking medical information.

Conclusions—Women seeking care for PFDs vary in their preferences for participating in treatment decisions.

Keywords

Decision making; Information seeking; Patient autonomy; Patient preferences; Pelvic floor disorders

Correspondence to: Vivian W. Sung, vsung@wihri.org.

Conflicts of interest None.

Introduction

The Institute of Medicine and US Preventive Services Task Force have encouraged physicians to engage patients in their own health care and have highlighted the importance of shared medical decision making and patient autonomy [1,2]. Shared decision making is defined as “a process in which patients are involved as active partners with the clinician in clarifying acceptable medication options and in choosing a preferred course of clinical care” [2]. Studies in general medical patients have shown that patients who take a more active role in their care are often more satisfied, more committed and have a better understanding of treatment plans, and experience greater improvement in health and patient-centered outcomes than do passive patients with various chronic diseases [3–5]. More recently, the American College of Obstetricians and Gynecologists has also acknowledged the benefits of shared medical decision making and has encouraged physicians to actively involve patients in their care in obstetrics and gynecology [6,7].

Shared medical decision making is particularly applicable to decision situations that are non-emergent with different treatment and tradeoff considerations for individual patients. Such decisions are common in women seeking care for pelvic floor disorders (PFDs). These treatments are aimed at improving a woman’s symptoms, functioning, and quality of life and are primarily based on a woman’s personal goals and values. In addition, numerous studies have highlighted the importance of reporting and improving patient-centered outcomes in PFDs [8,9]. The decision-making process and patient-centered outcomes in PFDs have the potential to be significantly improved through shared medical decision making.

However, studies suggest that not all patients necessarily want to be involved in medical decision making [10] and that pressure to take a more active role may provoke emotional distress in passively inclined patients [11–13]. Although questionnaires designed to assess patient preferences for autonomy regarding medical decision making have been previously developed and validated in other patient populations, they have not been well studied in women with PFDs. A validated questionnaire to measure women’s preferences would help to advance our knowledge in medical decision making and potentially improve patient care for women with PFDs. Therefore, the objective of this study was to validate two decision-making preference scales, the Autonomy Preference Index (API) and the Control Preferences Scale (CPS) in women with PFDs. Our secondary objective was to describe patient preferences and to identify variables associated with patient preferences for shared decision making using these two measures.

Material and methods

The API was originally developed and validated in general medical patients presenting for care to a hospital-based primary care clinic [14]. As part of instrument development, the authors performed two iterations of a modified Delphi study including 13 clinicians, medical sociologists, and ethicists to identify the key measurable dimensions of patients’ preferences for autonomy. The two most important dimensions identified that discriminated between patients preferring an active versus a passive role in their medical care included (1) patients’ desire for medical information (information seeking) and (2) patients’ preferences for making medical decisions (decision making). The final instrument, the API, consists of two scales: an eight-item information-seeking scale and a six-item decision-making scale. Scores for both domains range from 0–100, with higher scores indicating stronger preferences for participation. In addition, in the original API there are eight items corresponding to three clinical vignettes representing increasing disease severity to assess if symptom severity plays a role in patient autonomy preferences. The API has been validated and utilized in numerous other patient populations [14–16]. We adapted the API by modifying the

questions to be specific for decisions related to PFDs instead of general medical conditions (adapted scales provided in Appendix). In general, this involved substitution of general medical conditions such as “your medical problem” to “your pelvic floor problem”.

Degner et al. developed the CPS to assess the role that patients want to play in treatment decision making [17]. The control preference construct is defined as “the degree of control an individual wants to assume when decisions are being made about medical treatment”. The CPS consists of one item with a five-point scale that best describes the extent to which patients want to be involved in treatment decision making. Lower scores on the CPS indicate stronger preferences for involvement in decision making. Based on their responses to the five-point scale, patients are categorized as preferring an active role (“I prefer to make the final decision” or “I prefer to make the final decision after seriously considering my doctor’s opinion”), collaborative role (“I prefer that my doctor and I share responsibility for the decision”), or passive role (“I prefer that my doctor makes the decision after he/she seriously considers my opinion” or “I prefer my doctor to make the decision”). The CPS has also been validated and utilized in a variety of patient populations [17–20]. We adapted the CPS to be specific to women making treatment decisions for PFDs.

For our study, women aged 18 years and older who were seeking care for PFDs at our institution, including urinary incontinence, pelvic organ prolapse, and/or fecal incontinence, were enrolled in this study from October 2006 to October 2007. This study was approved by the Women and Infants Hospital of Rhode Island Institutional Review Board and all participants gave written informed consent. Participants completed the self-administered, adapted API and CPS at the time of enrollment and again 2 weeks later for questionnaire validation. Demographic and clinical variables were collected. At our institution, patients routinely complete the short forms of the Pelvic Floor Distress Inventory-20 (PFDI-20) and the Pelvic Floor Impact Questionnaire-7 (PFIQ-7) [21] at their first office visit, and these scores were also recorded. We excluded non-English-speaking patients and patients with cognitive impairments that might preclude them from completing the questionnaires. All patients underwent complete history and physical evaluations for PFDs.

The modified API and CPS were reviewed by two urogynecologists and a survey methodologist prior to administration for content validity. In addition, 20 participants were interviewed to confirm the relevance and content of the questionnaires following review by our panel. Internal consistency was assessed using Cronbach’s alpha and test–retest reliability was assessed using the intraclass correlation coefficient (ICC) to compare scores obtained at enrollment and those 2 weeks later. Given that there is no “gold standard” for measuring patient preferences for autonomy, concurrent validity was evaluated using the Pearson correlation coefficient between the API and the CPS. We hypothesized that the API decision-making scale scores and CPS role preferences would be negatively correlated and we used Cohen’s guidelines for the interpretation of correlation coefficients in behavioral sciences, with a correlation of 0.10 being small, correlation of 0.30 moderate, and a correlation of 0.50 being large [22]. Associations between demographic and clinical variables and API and CPS scores were explored in univariate analyses including analysis of variance, Pearson’s correlation coefficient, and Fisher’s exact test as appropriate. We used multiple linear regression to identify correlates of API information-seeking and API decision-making scores and ordinal regression to identify correlates of decision-making role preferences based on CPS categories. For all models, we included age and education level based on previous studies suggesting these variables are independent predictors of preferences in other patient populations [10]. We also explored the effect of covariates found to be significant on univariate analysis ($P \leq 0.1$) for each of the measures.

Based on Walter et al. [23] for sample size estimates based on test–retest reliability, our null hypothesis was that ICC for the API would be moderate ($ICC \leq 0.6$) and our alternative was that ICC would be excellent ($ICC > 0.8$). At $\alpha = 0.05$ and $\beta = 0.80$, a sample of 40 women would be needed for questionnaire validation. For our secondary objectives, we wanted to account for multiple comparisons to identify predictors of patient preferences. We therefore aimed to recruit a total of 110 women. Analyses were performed using SAS 9.1 (SAS Institute Inc., Cary, NC, USA) and Stata 9.0 (Stata Corporation, College Station, TX, USA).

Results

A total of 110 women were recruited, 109 (99%) women had complete surveys at enrollment, and 93 (85%) had complete test–retest data. Overall, the mean age was 62 ± 15 years, 97% of participants were white, 2% were Hispanic, 83% were menopausal, and median parity was 2. The median Pelvic Organ Prolapse Quantification (POPQ) [24] stage was 2 (range 0–4), 34% of participants had prior urogynecologic surgery, 30% reported prolapse symptoms, and 70% reported incontinence symptoms. Additional demographic and clinical characteristics are presented in Table 1.

Both the API and CPS demonstrated good psychometric properties. The API demonstrated good internal consistency (Cronbach's $\alpha = 0.8$) and good test–retest reliability ($ICC = 0.7$). The CPS demonstrated moderate test–retest reliability ($ICC = 0.5$). Because the CPS consists of only one item, internal consistency is not applicable. As expected, there was moderate correlation between the API decision-making scale and the CPS ($r = -0.3$).

When analyzing baseline scores, we found that the mean score for the API information-seeking scale was 70 ± 32 , but the mean score for the API decision-making scale was significantly lower, 53.3 ± 17 , indicating that although women had a strong preference to be well informed, they were more neutral in their preference to participate in decision making ($P < 0.05$). In addition, the API information-seeking and API decision-making scores were not correlated with each other (Pearson $r = 0.1$, $P = 0.3$), further supporting that information seeking and decision making are distinct aspects of patient autonomy preferences. For the adapted API-clinical vignettes, worsening symptom severity was not associated with a change in treatment decision-making preference scores, and most women remained neutral, wanting to share decision making regarding conservative or surgical therapy with their physician even if symptoms hypothetically worsened ($P > 0.05$). Based on responses to the CPS, 44% of women seeking care for PFDs preferred an active role, 47% preferred a collaborative role, and 9% preferred a passive role in their treatment decision.

In multivariable analyses, higher education level was associated with higher API information-seeking scores (23 points mean increase in score for college graduates compared to less than high school education, $P = 0.02$ and 32 points mean increase for post-graduates compared to less than high school education, $P = 0.01$), whereas current anticholinergic therapy was associated with decreased API information-seeking scores (22 points mean decrease in score for current users versus never users, $P = 0.003$; see Table 2). Although significant on univariate analysis, age and prior behavioral or physical therapy were not associated with information-seeking preferences in multivariable analysis ($P > 0.05$). For the API decision-making scale, there was a trend for older women to have decreased preferences for participation in decision making, but this did not reach statistical significance after adjusting for education level and prior behavioral or physical therapy (Table 3). On univariate analysis, no clinical or demographic variables were associated with decision-making role preferences based on the CPS, and on ordinal regression, neither age nor education level were associated with CPS categories ($P > 0.05$ for both). Race; duration

of symptoms; number of PFD diagnoses; disease severity measured using the POPQ, PFDI, and PFIQ; and final treatment decision (surgical versus non-surgical) were not associated with either of the API scales or CPS scores.

Discussion

To date, there has been little research done in evaluating patient preferences for involvement in medical decision making in PFDs. In this study, we demonstrated that the modified API and CPS for PFDs, two instruments measuring patient preferences for participation in decision making, are valid and reliable in women seeking care for PFDs. In addition, using these instruments we found that although women may be neutral in their desire to participate in decision making, with most women preferring a collaborative role, women have strong preferences for being well informed when considering their treatment options.

Our study also highlights that variations may exist in patient preferences for involvement in treatment decision making in PFDs, and that not all patients want to play an active or completely autonomous role. These findings are consistent with studies of other patient populations, including general medical patients, cancer patients, and general population-based studies [14,25,26]. Although the Institute of Medicine encourages shared decision making, it also recognizes that not all patients want to be active participants [1]. Studies have shown that for patients who do not want to be active participants, offering a choice of treatments may precipitate increased emotional distress [13] and provoke anxiety in passively inclined patients [27]. A comprehensive review by Kiesler et al. concluded that tailoring patient–physician interactions to match patient preferences for involvement in decision making can lead to improved patient satisfaction and patient-centered outcomes [10] and that this may be more effective and appropriate than pressuring all patients to take active roles.

To date, there has been limited work done evaluating patient preferences for urinary incontinence. O'Donnell et al. used the CPS to evaluate patient preferences for decision making for urinary incontinence in a national Norwegian telephone survey and found that 60% of women preferred an active role, 24% preferred a collaborative role and 17% preferred a passive role. They found that age <60 years and higher education were associated with a preference for an active role [28,29]. In a second study, O'Donnell et al. used the CPS in an outpatient clinical setting in women seeking care for urinary incontinence in 15 European countries and found that age >65 years, lower education level, lower generic quality of life scores and living in certain European countries were associated with a preference for a passive role [30]. In our study, we did not identify any demographic or clinical variables associated with the CPS. Although we found that education level was associated with stronger information-seeking preferences, it was not associated with stronger decision-making preferences on the API or CPS. In addition, a higher proportion of our participants preferred a collaborative role over an active or passive role compared to O'Donnell.

There are several potential explanations for differences between our findings and those by O'Donnell. First, women who participate in a randomly selected telephone survey represent a very different population compared to women who are in the process of seeking care and undergoing evaluation for PFDs. Although many women may state that they prefer an active and more autonomous role on a random phone survey, these preferences may change once they are undergoing actual evaluation and are faced with actual treatment decisions. Second, our study population included women with all PFDs and not only urinary incontinence, which may further contribute to differences in our findings. Next, it is possible that variables associated with patient preferences may differ between the USA and Europe due to

differences in patient expectations and/or health care systems. In addition, O'Donnell et al. used only the CPS to evaluate patient preferences, whereas in addition to the CPS, we included the more comprehensive API, which distinguishes between two important aspects of patient autonomy. Because the CPS consists of only one item, it is possible that subject responses may incorporate aspects of both information-seeking and decision-making preferences, which cannot be differentiated with this instrument. Finally, unlike O'Donnell, we adjusted for other clinical variables such as prior behavioral or physical therapy, which may also explain the observed differences.

We did not find an association between preferences for either information seeking or decision making and disease severity, measured by duration of symptoms, physical exam findings, and PFDI and PFIQ scores or the API-clinical vignettes of differing disease severity. This is also consistent with other patient populations [19]. We did find that a history of prior behavioral or physical therapy for PFDs was associated with decreased preferences for information seeking, which may be considered when counseling patients. It seems possible that women who have had prior pelvic floor training or current anticholinergic therapy may already feel informed of their options. However, prior urogynecologic surgery was not significantly associated with either information-seeking or decision-making preferences in our multivariable models. It is possible that our study was not powered to detect these differences since this was not the primary objective of this study.

There are limitations to our study. Because there is no “gold standard” for measuring a woman's information-seeking or decision-making preferences, we were unable to establish criterion validity. Also, the test–retest reliability for the CPS was only moderate. Based on the cross-sectional design, we are unable to determine if women's preferences change during the course of their disease or evaluation. Although our study provides insight into what preferences patients report, we do not know how patients express or follow-through with these preferences when they are interacting with their physician. We are also unable to determine if tailoring patient care and counseling to meet patient preferences for decision making or potential development of a decision aid might lead to improved decision making and patient-centered outcomes in this population. Future research should continue to identify variables associated with patient preferences in PFDs and evaluate how to incorporate patient preferences into clinical practice.

In conclusion, we provide evidence that women seeking care for PFDs may vary in their preferences for autonomy regarding seeking medical knowledge and making treatment decisions. Because of the potential benefits of patient involvement, encouraging patients to participate in their own care seems appropriate and presenting all treatment options to women is still advised; however, our study highlights the importance for physicians to assess the needs of individual patients and understand the role each patient wishes to play in her care.

The pelvic floor disorders autonomy preference index

Pelvic floor disorders include urinary incontinence, pelvic organ prolapse, and fecal incontinence. These can cause many physical as well as emotional symptoms. Sometimes, decision-making about treatment for these disorders can be confusing and complex. The following questions ask about your preferences in the decision-making process for your pelvic floor conditions. Please answer all of the questions in the survey. If you are unsure about how to answer a question, give the best answer you can.

A. Decision-making preference

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. The important medical decisions about your pelvic floor problems (urinary incontinence, pelvic prolapse, fecal incontinence) should be made by your physician, not you.					
2. You should go along with your physician's advice even if you disagree with it.					
3. When undergoing surgery for your pelvic floor problems, you should not be making decisions about your own care.					
4. You should feel free to make decisions about everyday problems regarding your pelvic floor problems					
5. If your pelvic floor symptoms began to worsen, you would want your physician to take greater control of the decisions					
6. You should decide how frequently you need to have a check-up after surgery for your pelvic floor problems					
<hr/>					
B. Vignettes					
i. Suppose that you have a new pelvic floor problem and you have just had the first visit with a urogynecologist for this problem. Who should make the following decisions?					
	You alone	Mostly you	The doctor and you equally	Mostly the doctor	The doctor alone
7. When the next visit should be.					
8. Whether you should try exercises to see if this would improve your symptoms.					
9. Whether you should have surgery.					
10. What action you should take if your symptoms start to worsen.					
<hr/>					
ii. Suppose that your pelvic floor symptoms have started to worsen over the past few weeks after your visit with the urogynecologist. Who should make the following decisions?					
	You alone	Mostly you	The doctor and you equally	Mostly the doctor	The doctor alone
11. Whether you should be seen by the urogynecologist					
12. Whether you should try exercises to see if this would improve your symptoms.					
13. Whether you should have surgery.					

14. What action you should take if your symptoms get even worse.

C. Information-seeking preference

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
15. As your symptoms begin to worsen, you should be told more about your pelvic floor problems.					
16. You should understand what is happening inside your body causing the pelvic floor problems.					
17. Even if the news is not good, you should be well informed about your pelvic floor problems.					
18. Your physician should explain the purpose of any tests you do for your pelvic floor problems.					
19. You should be given information about your pelvic floor problems only when you ask.					
20. It is important for you to know all of the risks and benefits of your treatment options for your pelvic floor problems.					
21. Information about your pelvic floor problems is as important as the treatment.					
22. When there is more than one method to treat your pelvic floor problem, you should be told about each one.					

The control preferences scale

D. Please circle the statement that most accurately reflects your preferences regarding your role in making a decision regarding the treatment of your pelvic floor problems:

1. I prefer to make the final decision
2. I prefer to make the final decision after seriously considering my doctor's opinion
3. I prefer that my doctor and I share responsibility for the decision
4. I prefer that my doctor makes the decision after he/she seriously considers my opinion
5. I prefer my doctor to make the decision

Acknowledgments

Funding support Dr. Sung is supported by grant 5-K23-HD060665-01, National Institute of Child Health and Human Development and a National Center of Excellence in Women's Health Seed Grant, Women and Infants Hospital/Brown University

Abbreviations

PFD	Pelvic floor disorder
API	Autonomy Preference Index
CPS	Control Preferences Scale
PFDI-20	Pelvic Floor Distress Inventory-20
PFIQ-7	Pelvic Floor Impact Questionnaire-7
ICC	Intraclass correlation coefficient
POPQ	Pelvic organ prolapse quantification

References

1. Crossing the Quality Chasm: A New Healthcare System for the 21st Century. National Academy Press; Washington, DC: 2001. Improving the 21st Century Healthcare System.
2. Sheridan SL, Harris RP, Woolf SH. Shared decision making about screening and chemoprevention. A suggested approach from the U.S. preventive services task force. *Am J Prev Med.* 2004; 26:56–66. [PubMed: 14700714]
3. Hexzen-Klemens I, Lapinska E. Doctor–patient interaction, patients’ health behavior and effects of treatment. *Soc Sci Med.* 1984; 19:9–18. [PubMed: 6474225]
4. Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician–patient interactions on the outcomes of chronic disease. *Med Care.* 1989; 27:S110–S127. [PubMed: 2646486]
5. Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, et al. Systematic review of involving patients in the planning and development of health care. *BMJ.* 2002; 325:1263. [PubMed: 12458240]
6. ACOG Committee Opinion #320. Partnering with patients to improve safety. *Obstet Gynecol.* 2005; 106:1123–1125. [PubMed: 16260544]
7. ACOG Committee Opinion No. 395. Surgery and patient choice. *Obstet Gynecol.* 2008; 111:243–247. [PubMed: 18165420]
8. Elkadry EA, Kenton KS, Fitzgerald KS, Shott S, Brubaker L. Patient-selected goals: a new perspective on surgical outcome. *Am J Obstet Gynecol.* 2003; 189(6):1551–1557. [PubMed: 14710061]
9. Hullfish KL, Bovbjerg VE, Steers WD. Patient-centered goals for pelvic floor dysfunction surgery: long-term follow-up. *Am J Obstet Gynecol.* 2004; 191(1):201–205. [PubMed: 15295366]
10. Kiesler DJ, Auerbach SM. Optimal matches of patient preferences for information, decision-making and interpersonal behavior: evidence, models and interventions. *Patient Educ Couns.* 2006; 61:319–341. [PubMed: 16368220]
11. Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Soc Sci Med.* 1999; 49:651–661. [PubMed: 10452420]
12. Deber RB. Physicians in health care management: 7. The patient-physician partnership: changing roles and the desire for information. *Cmaj.* 1994; 151:171–176. [PubMed: 8039062]
13. Levy SM, Herberman RB, Lee JK, Lippman ME, D’Angelo T. Breast conservation versus mastectomy: distress sequelae as a function of choice. *J Clin Oncol.* 1989; 7:367–375. [PubMed: 2918332]
14. Ende J, Kazis L, Ash A, Moskowitz MA. Measuring patients’ desire for autonomy: decision making and information-seeking preferences among medical patients. *J Gen Intern Med.* 1989; 4:23–30. [PubMed: 2644407]
15. Schneider A, Wensing M, Quinzler R, Bieber C, Szecsenyi J. Higher preference for participation in treatment decisions is associated with lower medication adherence in asthma patients. *Patient Educ Couns.* 2007; 67:57–62. [PubMed: 17346917]

16. Spies CD, Schulz CM, Weiss-Gerlach E, Neuner B, Neumann T, von Dossow V, et al. Preferences for shared decision making in chronic pain patients compared with patients during a premedication visit. *Acta Anaesthesiol Scand*. 2006; 50:1019–1026. [PubMed: 16923100]
17. Degner LF, Sloan JA, Venkatesh P. The control preferences scale. *Can J Nurs Res*. 1997; 29:21–43. [PubMed: 9505581]
18. Beaver K, Luker KA, Owens RG, Leinster SJ, Degner LF, Sloan JA. Treatment decision making in women newly diagnosed with breast cancer. *Cancer Nurs*. 1996; 19:8–19. [PubMed: 8904382]
19. Kremer H, Ironson G, Schneiderman N, Hautzinger M. “It’s my body”: does patient involvement in decision making reduce decisional conflict? *Med Decis Making*. 2007; 27:522–532. [PubMed: 17873261]
20. Chapple H, Shah S, Caress AL, Kay EJ. Exploring dental patients’ preferred roles in treatment decision-making—a novel approach. *Br Dent J*. 2003; 194:321–327. discussion 317. [PubMed: 12682659]
21. Barber MD, Walters MD, Bump RC. Short forms of two condition-specific quality-of-life questionnaires for women with pelvic floor disorders (PFDI-20 and PFIQ-7). *Am J Obstet Gynecol*. 2005; 193:103–113. [PubMed: 16021067]
22. Cohen, J. *Statistical power analysis for the behavioral sciences*. 2. Lawrence Erlbaum Associations, Inc; NJ: 1988.
23. Walter SD, Eliasziw M, Donner A. Sample size and optimal designs for reliability studies. *Stat Med*. 1998; 17:101–110. [PubMed: 9463853]
24. Bump RC, Mattiasson A, Bo K, Brubaker LP, DeLancey JO, Klarskov P, et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol*. 1996; 175:10–17. [PubMed: 8694033]
25. Levinson W, Kao A, Kuby A, Thisted RA. Not all patients want to participate in decision making. A national study of public preferences. *J Gen Intern Med*. 2005; 20:531–535. [PubMed: 15987329]
26. Street RL Jr, Millay B. Analyzing patient participation in medical encounters. *Health Commun*. 2001; 13:61–73. [PubMed: 11370924]
27. Hack TF, Degner LF, Dyck DG. Relationship between preferences for decisional control and illness information among women with breast cancer: a quantitative and qualitative analysis. *Soc Sci Med*. 1994; 39:279–289. [PubMed: 8066506]
28. O’Donnell M, Hunskaar S. Preferences for involvement in treatment decision-making among Norwegian women with urinary incontinence. *Acta Obstet Gynecol Scand*. 2007; 86:1370–1376. [PubMed: 17851820]
29. O’Donnell M, Hunskaar S. Preferences for involvement in treatment decision-making generally and in hormone replacement and urinary incontinence treatment decision-making specifically. *Patient Educ Couns*. 2007; 68:243–251. [PubMed: 17904327]
30. O’Donnell M, Monz B, Hunskaar S. General preferences for involvement in treatment decision making among European women with urinary incontinence. *Soc Sci Med*. 2007; 64:1914–1924. [PubMed: 17360093]

Table 1Demographic and clinical characteristics of study population (*N*=109)

Characteristic	
Age, mean years (SD)	62.2 (14.8)
Education level, <i>n</i> (%)	
Did not complete high school	14 (12.8)
Completed high school/some college	40 (36.7)
Completed college	28 (25.7)
Post-graduate degree	8 (7.3)
Prior urogynecologic surgery, <i>n</i> (%)	37 (34.0)
Prior behavioral or physical therapy treatment, <i>n</i> (%)	22 (20.2)
Anticholinergic use, <i>n</i> (%)	
Current	28 (25.7)
Prior	15 (13.8)
None	63 (57.8)
Duration of symptoms, mean months (SD)	
Prolapse symptoms	47 (44.8)
Incontinence symptoms	66.4 (72.2)
Defecatory symptoms	28.3 (29.7)
Symptomatic incontinence, <i>n</i> (%)	
Stress incontinence	58 (53.2)
Urge incontinence	68 (62.4)
Mixed incontinence	44 (40.4)
Incomplete emptying	34 (31.2)
Number of pelvic floor diagnoses per patient, <i>n</i> (%)	
1	36 (33.0)
2	37 (35.2)
3	32 (30.5)
PFDI score, mean (SD)	90.5 (55.6)
PFIQ score, mean (SD)	44.0 (43.9)

Percentages may not add up to 100% due to missing data

Table 2

Multiple linear regression analysis of variables associated with information-seeking preferences in pelvic floor disorders^{a,b} ($N = 104$)

Variable	Mean change in score	Standard error	P value
Age (change in score per 1-year increase)	-0.03	0.25	0.9
Education ^c			
High school graduate or some college	-1.3	9.1	0.88
College graduate	23.2	9.4	0.02
Post-graduate	32.2	12.7	0.01
Prior behavioral or physical therapy	-11.6	8.4	0.17
Anticholinergic use ^d			
Current anticholinergic use	-22.5	7.3	0.003
Previous anticholinergic use	0.07	9.2	0.99

^aInformation-seeking preference measured using the Autonomy Preference Index information-seeking scale

^bVariables with $P \leq 0.1$ on univariate analysis included in model, in addition to age and education level

^cCompared to less than high school education

^dCompared to never use of anticholinergic medication

Table 3

Multiple linear regression analysis of variables associated with decision-making preferences in pelvic floor disorders^{a,b} (N=104)

Variable	Mean change in score	Standard error	P value
Age (change in score per 1-year increase)	-0.24	0.13	0.07
Education ^c			
High school graduate or some college	-3.5	4.9	0.47
College graduate	0.37	5.0	0.94
Post-graduate			
Prior behavioral or physical therapy	7.1	4.3	0.10

^a Decision-making preference measured using the Autonomy Preference Index decision-making scale

^b Variables with $P \leq 0.1$ on univariate analysis included in model, in addition to age and education

^c Compared to less than high school education