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ORIGINAL ARTICLE

Decisional conflict in asthma patients: a cross sectional study

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Abstract

Objective: This study aimed at determining the level of decisional conflict in asthmatic individuals facing recommendation-based decisions provided to improve asthma control. **Methods:** This was a cross-sectional study performed on a convenience sample of 50 adults aged between 18 and 65 years with a diagnosis of asthma. They completed a decisional conflict scale (possible range of 0–100%), asthma knowledge and control questionnaires (both 0% and 100%), and a general questionnaire on socio-demographic characteristics. A decisional conflict was considered clinically significant with a score greater than 37.5%. Simple descriptive statistics were used to investigate associations with decisional conflict. **Results:** Participants were mainly women (76%) and diagnosed with mild asthma (72%). The median age (1st and 3rd quartile) was 25 years (22 and 42). The median score (1st and 3rd quartile) of decisional conflict was 33% (24 and 44). A clinically significant score (>37.5%) was obtained in 36% of subjects. A statistically significant negative correlation between the knowledge score and the decisional conflict score ($r_p = -0.38$; $p = 0.006$) was observed. The level of knowledge was the only statistically independent variable associated with the decisional conflict score ($p = 0.0043$). **Conclusions:** A considerable proportion of patients with asthma have a clinically significant level of decisional conflict when facing decisions aimed at improving asthma control. Patients with poor knowledge of asthma are more at risk of clinically significant level of decisional conflict. These findings support the relevance of providing asthmatic patients with relevant information in decision aids.

Keywords

Asthmatic, decisional conflict scale, decision-making, knowledge

History

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Introduction

Asthma is a highly prevalent chronic disease, affecting about 300 million individuals worldwide and representing a major economic burden [1]. Although asthma cannot be cured, optimal control can be achieved in most patients [2,3].

Asthma control depends on having adequate asthma management [4]. Control is evidenced by the absence of troublesome asthma symptoms and optimal pulmonary function under appropriate treatment. In order to achieve this goal, patients face many options resulting in numerous difficult decisions, some of them being informed by evidence-based recommendations [2]. These decisions may vary according to perceived asthma severity, knowledge about the illness, and the belief that patients are playing an active role in maintaining the illness under control [2]. Unfortunately, a high proportion of patients do not implement recommendations, resulting in sub-optimal control of asthma, increased

health care use, mortality, and morbidity [5]. Proper adherence to asthma maintenance treatment is recognized to be generally sub-optimal, poor adherence being observed in 30–70% of patients thus suggesting underuse of proven evidence-based asthma control options [5–7]. Various factors have been reported to explain this situation but further research is needed to address this care gap [8].

The decisional conflict is a key element of the decision-making process, in the healthcare system, for patients having difficulty to make a decision when confronted to several available options involving various risks and benefits [9–13]. A decisional conflict occurs when patient feels uncomfortable about a decision. Decisional conflict might be influenced by a number of factors such as the lack of knowledge, unrealistic expectations, uncertainty and unclear values, inadequate support, and the perception that an ineffective decision has been made and tends to increase with the number of choices available and decrease as the decision is made [9,14]. The presence of unresolved decisional conflict may lead to a decision that is not consistent with the patient's healthcare preferences, with a possibly negative impact on patients' outcomes [15].

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Decisional conflict in healthcare is considered clinically significant when it is likely to have adverse effects on the patient and to result in a delayed decision by this last.

To our knowledge, decisional conflict has not been explored in individuals facing decisions aimed at controlling asthma. This is a significant gap in knowledge because it hampers the proper decisional needs assessment of these patients and lowers the capacity of the healthcare system to provide decision support and to implement shared decision making (SDM) strategies. SDM is increasingly advocated to involve the patient in the decision process when several treatment options exist and to reduce decisional conflict [16]. SDM has also been shown to improve adherence to asthma treatment, in keeping with evidence-based recommendations [17].

We, therefore, aimed to determine the level of decisional conflict in asthmatic individuals facing decisions required to control asthma. Moreover, we explored factors that may be associated with decisional conflict in patients with asthma.

Methods

Participants and recruitment strategy

This was a cross-sectional study performed on a convenience sample of patients between 18 and 65 years old with mild to severe asthma diagnosed prior to the recruitment. They were either recruited from the specialized chest clinic (SCC) or from the *Institut universitaire de cardiologie et de pneumologie de Québec* research center. Initial screening was done by looking at patients' medical records to determine eligibility according to age, prior asthma diagnosis and date of last asthma educational session. Thereafter, these criteria were confirmed using a general questionnaire. If patients met the inclusion/exclusion criteria, they were asked to participate to the study. Patients were excluded if they had received formal asthma education in the 2 years prior to their study participation. In the research center, only new patients or patients who had not participated in an asthma-related research project 2 years prior to this study were recruited. All subjects enrolled signed a written informed consent form. This study was approved by the local Ethics Committee.

Data collection

A study coordinator met with each patient and ensured that data collection was carried out using standard questionnaires, including demographic information and medical asthma history. The Asthma Control Scoring System (ACSS) was completed during the interview [18]. Finally, the participant completed the decisional conflict scale and an asthma knowledge questionnaire [19,20].

Dependent variable

Decisional conflict scale

The dependent variable was the decisional conflict score on decisions about asthma management, analyzed as a continuous variable. In order to measure this score, subjects were asked to complete the decisional conflict scale (DCS) (Appendix 1), a self-administered questionnaire about decisions they had faced, prior to the study, to help

achieve asthma control. The DCS has been developed by O'Connor [21], translated by Légaré et al. [19], and adapted for asthmatic patients. The DCS has been used in many studies on healthcare decisions [22–25]. It is recognized as a standard in the assessment of uncertainties and modifiable factors associated with the decision-making process in healthcare [13]. It includes 16 questions scored on a Likert scale from 1 – strongly agree, to 5 – strongly disagree. This questionnaire measures individual uncertainty about the options and factors contributing to uncertainty [21]. The global mean score for each subject is reported as a percentage by subtracting one to the mean score and by multiplying this last by 25 [21]. Global scores lower than 25% are associated with implementing decisions and scores greater than 37.5% are considered to result in delayed decisions or uncertain implementation [21]. Decisional conflict was considered clinically significant when it was higher than 37.5%. Subscores on uncertainty in choosing options, feeling uninformed, unclear about personal values, unsupported, and on ineffective decision making were also determined by calculating the mean score of each section.

Furthermore, Cronbach's alpha was used to assess reliability of the decisional conflict scale we adapted for asthma. Cronbach's alpha coefficient was 0.94.

Independent variables

General questionnaire

A general questionnaire gathered socio-demographic information such as age and gender. It also contained questions on asthma medical history.

Asthma Control Scoring System (ACSS)

The level of asthma control was measured with the ACSS, a validated questionnaire developed to quantify the level of asthma control [18]. The ACSS used is a validated French questionnaire which control criteria have been based on the Canadian Asthma Consensus Guidelines [18]. Moreover, this questionnaire has good psychometric properties; sufficient internal consistency (Cronbach's alpha ranging from 0.72 to 0.88 for each section) and an acceptable test–retest reliability (Pearson correlation coefficient = 0.65, $p = 0.001$ for the global score) [18]. The global score of this questionnaire is based on the mean of clinical, physiological, and inflammatory scores, whenever available. The clinical score is based on the frequency of symptoms; the physiological score is based on expiratory flows (forced expiratory volume in one second (FEV₁) and/or peak expiratory flow (PEF)); the inflammatory score is quantified by the percentage of sputum eosinophils. Each section has the same weight in the calculation of the global score and can be used separately. Based on the criteria of the Canadian asthma Consensus Guidelines, a score less than 80% asthma suggests that asthma is sub-optimally controlled. Questions on asthma medication were added at the end of this questionnaire to assess severity. Asthma severity was determined according to medication needs assessed by the treating physician. Asthma was considered mild if it only required a low-dose inhaled corticosteroids (ICS) equivalent to 250 µg or less of fluticasone propionate, moderate if the

ICS dose required was $\geq 251 \mu\text{g}$ to $\leq 500 \mu\text{g}$ with or without additional medications and severe when ICS dose was $> 500 \mu\text{g}$, with other add-on medications, as suggested by the Canadian Respiratory Guidelines [26].

Knowledge questionnaire (KQ)

The *Questionnaire de connaissances sur l'asthme en langue française*, a validated French questionnaire on asthma knowledge, was completed by subjects to assess their level of knowledge about asthma and its management [20]. This questionnaire is self-administered and includes choices of answers as either “true”, “false”, or “I do not know”. The original questionnaire contains 38 questions, but one question was removed as it did not apply to our population. Furthermore, the authors calculated attributes scores in two different ways, according to the score that was given to the unknown answer. For the present study, as it was not necessary to differentiate between a wrong and an unknown answer, and one point was given for a valid answer while a score of zero was given for every “I do not know” or wrong answer. The global score equals the sum of all questions with a possible score ranging from 0 to 37.

Data analysis

Simple descriptive statistics were used. Relationships between the decisional conflict score (the dependent variable) and the independent variables were investigated first using Pearson's correlation coefficient and graphical representations. Variables with p values ≤ 0.20 were candidates for multivariate linear regression analysis. Decisional conflict score was log transformed to fulfill the homogeneity of variance and normality assumptions. The univariate normality assumptions were verified with the Shapiro–Wilk tests. The results were considered significant with p values ≤ 0.05 . All analyses were conducted using the statistical package SAS, version 9.3 (SAS Institute Inc., Cary, NC).

Results

Patients' characteristics

A flowchart details how patients were recruited (Figure 1). From the 661 eligible patients, 38 and 13 patients were recruited at the research center and the SCC, respectively. All patients ($n=51$) agreed to participate and only one was excluded due to an unsigned informed consent form. The subjects' characteristics are shown in Table 1. Mean ($\pm$ standard deviation) age was 33 (± 14) years, including mainly women (76%). More than twice as many individuals had mild (72%) compared to moderate asthma (26%). Only one participant had severe asthma. Most participants were followed by a practitioner for their asthma (72%) and had not participated in an asthma education session during the 2 years prior to the study (88%). Six patients (12%) who had met an asthma educator in the past 2 years were enrolled as they only had the inhaler technique reviewed during the visit. Their decisional conflict scores were not statistically different from those who did not meet with an asthma educator (data not shown).

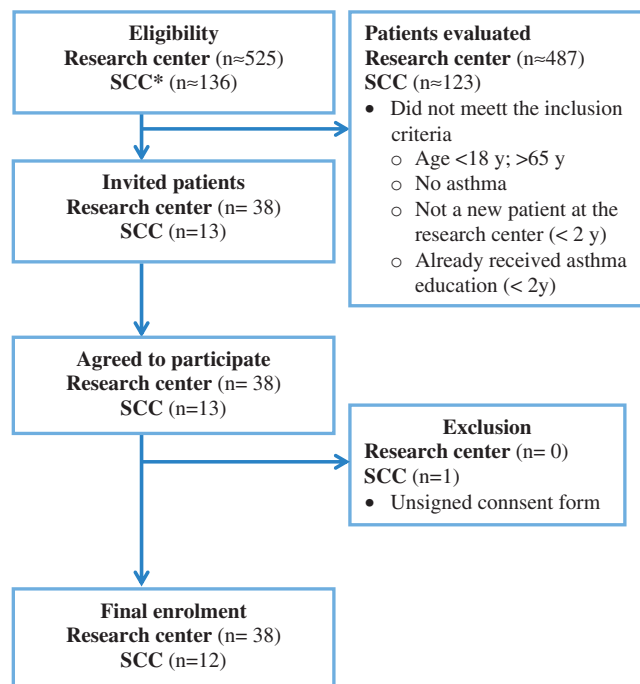


Figure 1. Flow of patient throughout the study.

Asthma control

All patients completed the ACSS clinical and physiological sections. For six subjects, the ACSS score was only based on the clinical score. For the others, FEV₁ was available and asthma control was determined from the mean of clinical and physiological scores. All subjects completed the ACSS. They were generally well controlled, with an ACSS median score (1st and 3rd quartile) of 83% (75% and 90%) (Table 1).

Asthma knowledge

All patients filled the asthma knowledge questionnaire. The median score (1st and 3rd quartile) was 28% (25% and 29%) and the mean score ($\pm$ standard deviation) was 27 ± 5 (Table 1). The proportion of missing answers was very low, 7/1850 (0.4%). In these cases, the result was considered missing and the score was summed and reported on 37 items.

Decisional conflict scores

Results for the decisional conflict score and subscores of factors contributing to uncertainty are presented in Table 2. The median (1st and 3rd quartile) decisional conflict score was 33 (24 and 44). All subscores were greater than or equal to 25% but less than 37.5%. The subscores “feeling uninformed” and “uncertainty in choosing options” had the highest median scores. Table 3 shows the frequency of categorical decisional conflict score. Thirty-six percent of subjects had a clinically significant global score ($> 37.5\%$).

Variables associated with decisional conflict

Analysis from Pearson's correlations between logarithmic decisional conflict score and continuous variables showed a statistically significant negative correlation ($r_p = -0.38$; $p = 0.006$) between the knowledge score and the

Table 1. Subject's characteristics (n = 50).

Characteristics	
Age (years), mean ± SD ^a	33 ± 14
Gender (♀), n (%)	33 (76%)
Asthma severity	
Mild, n (%)	36 (72%)
Moderate, n (%)	13 (26%)
Severe, n (%)	1 (2%)
Place of recruitment (research center), n (%)	38 (76%)
Followed by a practitioner for their asthma (yes), n (%)	36 (72%)
Received asthma education in the last 2 years (yes), n (%)	6 (12%)
Patient's knowledge score (/37), median (Q1 and Q3) ^b	28 (25 and 29)
ACSS ^c %, median (Q1 and Q3)	83 (75 and 90)

^aSD, standard deviation.
^bQ1: lower quartile; Q3: upper quartile.
^cACSS: Asthma Control Scoring System.

Table 2. Decisional conflict score and subscores (n = 50).

Score ^a (%)	Median (Q1 and Q3 ^b)
Decisional conflict total	33 (24–44)
Subscores (%)	
Uncertainty in choosing options	33 (25–50)
Feeling uninformed	33 (25–58)
Unclear about personal values	25 (17–42)
Unsupported in decision making	25 (17–50)
Ineffective decision making	28 (25–38)

^aRange 0–100%: global mean score for each subject is reported as a percentage by subtracting one to the mean score and multiplying it by 25.
^bQ1: lower quartile; Q3: upper quartile.

Table 3. Frequency of categorical decisional conflict score^a (n = 50) and correlation with knowledge scores.

Categorical scores	Frequency, n (%)	Mean knowledge score ± SD	Pearson correlation ^b	p Value
≤25.0	16 (32)	28 ± 3	−0.54592	0.0287
>25.0 to ≤ 37.5	16 (32)	27 ± 4	−0.57065	0.0210
>37.5 to ≤ 50.0	13 (26)	25 ± 5	0.20436	0.5030
>50.0 to ≤ 75.0	3 (6)	25 ± 7	−0.70654	0.5005
>75.0	2 (4)	22 ± 8	1.00000	–

^aGlobal scores lower than 25% are associated with implementing decisions and scores greater than 37.5% are considered to result in delayed decisions or uncertain implementation. Decisional conflict was considered clinically significant when it was higher than 37.5%.
^bPearson correlation between decisional conflict scores and knowledge scores for each category. The decisional conflict score suffered a log transformation.

decisional conflict. A statistically significant difference of the decisional conflict score was observed between subjects who were followed by a physician for their asthma and those who were not. Age, knowledge score and being followed by a physician were the three variables included in the multivariate model of the logarithmic decisional conflict score as shown in Table 4. Only the knowledge score was associated with the decisional conflict score. Poor knowledge resulted in higher decisional score. Consequently, the final model only included the level of knowledge.

Table 4. Multivariate model of the decisional conflict score^a (n = 50).

Variables	Regression coefficients	Standard error	p
Intercept	6.04696	0.71225	<.0001
Age	−0.01575	0.00796	0.0540
Knowledge score	−0.07278	0.02425	0.0043
Followed by a doctor	−0.41815	0.24251	0.0914

^aScore underwent logarithmic transformation.

Discussion

To our knowledge, this study is the first to assess decisional conflict in asthmatic individuals facing decisions aiming to control asthma symptoms and to explore which factors may be associated with such decisional conflict. This study initially aimed to describe a sample of 50 patients with asthma on their characteristics including decisional conflict and we explore some correlations. Overall we found that (1) many asthmatics feel decisional discomfort when having to decide about control asthma symptoms options and (2) the level of asthma knowledge is associated with decisional conflict.

Our data analysis shows that 36% of our participants experienced a clinically significant decisional conflict according to the threshold used in this study. This threshold was suggested by the developers of the decisional conflict scale [21] and used in other studies [27–29]. This proportion of clinically significant decisional conflict is in keeping with the 30–70% of patients generally considered not adherent to their treatment as proposed by their physician [5–7]. Lack of adherence to treatment remains the most common reason for the lack of asthma control [2]. An informed decision based on evidence and consistent with patient's preferences and values leads to low decisional conflict and consequently, low decision regret. Patients with low decision regret are more likely to adhere to treatment [30,31]. This underlines the need for further studies on the link between decisional conflict and adherence. Indeed, individuals with clinically significant level of decisional conflict represent individuals who have not experienced an optimal decision making process and whose decision's quality is most probably poor. In turn, this may

reflect an underuse of evidence-based recommendations on asthma control. Therefore, it seems reasonable to envision future research on how to increase decision support in this population.

Empowerment of the patient is considered essential to ensure quality of the decision-making process and then adherence to asthma control option since ultimately, the patient is the one deciding to follow or not the treatment. When patient's preferences and values are taken into account, the likelihood of adherence to the chosen option increases [32,33]. Moreover, in the context of underuse of effective care, empowering patients with evidence and a structured decision making process that clarifies what is important for them is considered to help adherence to recommendations [34]. Shared decision making is a collaborative model between two actors involved in a decision, patients expressing their values and expectations and physicians providing evidence-based information on the available treatment options with their risks versus benefits. Such strategy is considered of interest to decrease decisional conflict in patients with asthma, reducing decisional regret and hopefully improving adherence to treatment in providing better consistency between the treatment chosen and valued outcomes [31,35]. SDM has, therefore, been considered an optimal way to involve patients in health care decisions [15,33]. SDM has been suggested as a mean to improve the management of many chronic diseases, resulting hopefully in an improvement of health outcomes [36–42]. In such context, when symptoms fluctuate, as in asthma, treatment may need to change over time and patients decision making aids has, therefore, been increasingly advocated [10,41,42].

Nevertheless, some barriers have been perceived by decision makers when implementing SDM [43]. The length of the duration of the consultation is the most frequently reported barrier to SDM according to Legare [43]. However, systematic reviews on SDM implementation or use of decision aids suggest that there they do not systematically increase consultation duration [34]. Clinicians also think that SDM cannot be used in vulnerable people as it requires a specific set of skills and it may be too complex for such population. Even if many surveys showed that vulnerable people are less willing to participate in SDM, it is important to not increase health inequities in offering SDM only to privileged patients [43]. Legare et al. [44] reported that individuals with low literacy are interested in participating in health decisions but often lack of knowledge, skills, and confidence to engage in SDM. According to Mancuso et al. [45], asthma patients with a lower level of literacy are more likely not to participate in decisions about their care; therefore, education on asthma management should be adapted. Our study did not, however, explore the level of literacy and thus we cannot conclude on its relationship with decisional conflicts. This can be a topic for future research. Nevertheless, we agree that developers of decision support tools should consider adapting those to various levels of health literacy.

Our main observation was, however, that there is a statistically significant negative correlation ($p=0.006$) between scores of knowledge and of decisional conflict. In a multivariate model, the knowledge score was the only

variable remaining statistically significant ($p=0.0043$). These results suggest that patients with less knowledge on asthma feel more discomfort with decisions regarding their asthma management. In a study in which patients should decide if they want to participate or not in a cancer clinical trial, those with increased knowledge were more prepared to make this decision [46]. Furthermore, decreased decisional conflict was associated with the decision to participate in the cancer clinical trial [46]. In keeping with this, our results showed that knowledge was a contributing factor to decisional conflict. Furthermore, the subscore “feeling uninformed” was one of the highest scores, meaning that patients need to feel they have received enough information to reduce their decisional conflict. This suggests that if people with asthma had more knowledge of their disease, they would feel less discomfort and their decisional conflict would decrease, which could lead to better decision making in their asthma management and increase their adherence to treatment. Those results reinforce the notion that lack of knowledge on asthma is an important factor to consider in further interventions focusing on reducing decisional conflict. It, therefore, further supports the development of decision aids in asthma management. Indeed, decision aids have been shown to result in better outcome than usual care interventions in increasing knowledge and in reducing decisional conflict related to feeling uninformed [26]. Furthermore, a systematic review comparing usual care, decision aids and decision aids plus coaching showed that knowledge improved in using decision aids with or without coaching [47].

Finally, using bivariate analysis, a statistically significant difference in decisional conflict score was found between people who were followed by a physician for their asthma and those who had no follow-up and this variable was included in the multivariate model. However, it was not statistically significant in the multivariate model. This may be due to the limited size of our patient sample size. The interdependence between the health professional and the patient in a dyadic approach in clinical decision making has been recognized [14,48]. In addition, according to a patient's perspective of the dyad patient–physician in the clinical encounter, SDM interventions, focusing on healthcare provider and patient, seems promising in translating shared decision making during patient's visits [49]. Age was also included in the multivariate model. Many studies showed an influence of age in preference for involvement in medical decisions [50]. Hölzel et al. [50] found a negative association between age and preference for involvement in their model of shared decision making in primary care [50]. This suggests that with increasing age, patients are less preference for involvement shared decision making. In our study, the influence of age on decisional conflict has not been found. This could be explained by our small sample size or because age impact on another component in the decision making process. That avenue on association between patient followed by doctor or age and decisional conflict should be more thoroughly explored in a larger sample of asthmatic patients.

We recognize that this study has limitations. First, we recruited patients in a tertiary hospital and not in a community-based setting, which means that the decisional conflict score found in this study may not be representative of

the overall asthmatic population, although we could expect that decisional conflict could even be more common in settings such as primary care. Second, although we included new patients or patients who had not received asthma education in the past two years, some of them were healthcare workers or medical students, so that the knowledge score could be better than in the general population. Nevertheless, we found a correlation between knowledge and decision score. As in our study, patients were generally well controlled; no association was found in bivariate analysis between asthma control and decisional conflict score. This could have been different in poorly control patients. Furthermore, a measurement bias may have occurred as no precise decision point was mentioned in the decisional conflict scale, which makes it more difficult to measure.

Our sample was mostly constituted of women and people with mild asthma. O'Connor et al. [51] showed that decisional conflict was significantly higher in woman facing complex health decisions. The gender bias from represented by the higher number of women in our sample could affect the decisional conflict score. However, we found no statistical difference with regard to gender. Also, the presence of a majority of patients with mild asthma could be seen as a factor influencing decisional conflict. Patients with severe asthma experience more frequent and more severe asthma-related symptoms. We could hypothesize that decisional conflict could be higher in that population. Our analysis showed no statistical difference in decisional conflict between mild and moderate asthma. We could not, however, investigate the difference between mild and severe asthma due to the insufficient number of patients with severe asthma in our study. This should be further explored.

Conclusion

In conclusion, this study is original, as it provides new information on the decisional conflict asthma patients have when specific decisions should be made in order to improve asthma control. A significant proportion of this population showed discomfort when facing multiple options to control their asthma. Furthermore, this discomfort is associated with asthma knowledge. Improving knowledge can, therefore, be a key intervention to reduce decisional conflict. This study supports the need for developing decision aids and shared decision-making interventions in purpose to reduce decisional conflict and improve knowledge in asthma management. Further studies could also assess decisional conflict in healthcare providers, to shed more light on the dyadic approach in asthma encounters.

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Declaration of interest

Dr. Louis-Philippe Boulet is Chair of the Global Initiative for Asthma Dissemination and Implementation Committee, and holds the Laval University Chair in Knowledge Translation,

Prevention and Education in Respiratory and Cardiovascular Health and has no conflict of interest. France Légaré, is Canada Research Chair in Implementation of Shared Decision Making in Primary Care. In addition, Dr Boulet and Dr Légaré are members of Knowledge Translation Canada (KT Canada). Dr Légaré has no conflict of interest. Annick Des Cormiers received funds from Allergen NCE but has no conflict of interest to declare. Finally, Serge Simard has no conflict of interest to declare.

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Appendix 1

Traditional Decisional Conflict Scale (DCS) – Statement Format: 16 item 5 response categories

This is our most tested version. Many people like the personal response format. However, it is more difficult to respond to than questions in those with limited reading and response skills.

Note: We always precede the DCS with an option preference question, which is not included in scoring.

[See item ‘A’ below].

My difficulty in making this choice

A. Which [insert treatment/screening] option do you prefer? Please check ☒ one.

- ☐ [Option 1]
☐ [Option 2]
☐ [Option 3]
☐ Unsure

B. Considering the option you prefer, please answer the following questions:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
	[0]	[1]	[2]	[3]	[4]
1. I know which options are available to me.	☐	☐	☐	☐	☐
2. I know the benefits of each option.	☐	☐	☐	☐	☐
3. I know the risks and side effects of each option.	☐	☐	☐	☐	☐
4. I am clear about which benefits matter most to me.	☐	☐	☐	☐	☐
5. I am clear about which risks and side effects matter most to me.	☐	☐	☐	☐	☐
6. I am clear about which is more important to me (the benefits or the risks and side effects).	☐	☐	☐	☐	☐
7. I have enough support from others to make a choice.	☐	☐	☐	☐	☐
8. I am choosing without pressure from others.	☐	☐	☐	☐	☐
9. I have enough advice to make a choice.	☐	☐	☐	☐	☐
10. I am clear about the best choice for me.	☐	☐	☐	☐	☐
11. I feel sure about what to choose.	☐	☐	☐	☐	☐
12. This decision is easy for me to make.	☐	☐	☐	☐	☐
13. I feel I have made an informed choice.	☐	☐	☐	☐	☐
14. My decision shows what is important to me.	☐	☐	☐	☐	☐
15. I expect to stick with my decision.	☐	☐	☐	☐	☐
16. I am satisfied with my decision.	☐	☐	☐	☐	☐