

# Improving the Quality of Decision Making in Breast Cancer: Consultation Planning Template and Consultation Recording Template

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**Purpose/Objectives:** To describe two templates that can be used to improve the quality of breast cancer treatment decisions.

**Data Sources:** Case study, survey of current users, three clinical trials.

**Findings:** Clinical applications of the Consultation Planning Template and Consultation Recording Template vary across organizations. Clinical trials have demonstrated that the templates can improve the quality of decisions, the quality of communication between patients and providers, and satisfaction.

**Conclusions:** The templates can be adapted to different clinical settings and can improve the quality of treatment decisions.

**Implications for Nursing:** Nurses often provide the majority of education and coaching for patients making decisions. As patients' demands for involvement in decision making increase, nurses need practical tools to help patients participate. The templates are practical tools that nurses can use to help patients make better decisions.

Between diagnosis and treatment, patients and providers make decisions that significantly affect patients' lives. However, unlike diagnosis and treatment, patients and providers do not have protocols or guidelines for decision making. This lack of systematic support for decision making between diagnosis and treatment of cancer can be considered a "decision gap."

Filling this gap poses several challenges. Patients have variable needs for information—some want as much as possible, but others want limited information—and those needs may change over time (Rees & Bath, 2001). With the explosion of information available to patients through the media, libraries, and the Internet, a common complaint for patients with breast cancer is information overload (Sepucha, Belkora, Mutchnick, & Esserman, 2002). Patients are not able to figure out what information matters to them (Berland et al., 2001).

In addition, patients are not always well prepared to present concerns or ask questions in consultations. Some are too upset with the diagnosis (Cimprich & Ronis, 2001). Others do not know what questions to ask. Still others withhold their questions and concerns for fear of wasting physicians' time (Marvel, Epstein, Flowers, & Beckman, 1999; Roter & Hall, 1987; Suchman, Markakis, Beckman, & Frankel, 1997; White, Levinson, & Roter, 1994).

During the course of a medical consultation, a significant amount of material is presented. Unfortunately, patients often

## Key Points . . .

- ▶ Many patients with breast cancer want to participate in decisions about treatment.
- ▶ Implementing shared decision making in clinics can be difficult because of time pressure, lack of resources, and lack of training. Providers need practical tools to help patients productively participate in decisions.
- ▶ Consultation Planning and Recording Templates help patients prepare for and summarize discussions with providers about treatment decisions. Nurses can use the templates to encourage patient participation in decisions about treatment.

leave confused, overwhelmed, and unsure about what is supposed to happen next and, sometimes, unclear if decisions were made (Lobb, Butow, Kenny, & Tattersall, 1999; Sepucha, 1999). Guidelines for conducting a medical interview (Lipkin, Putnam, & Lazare, 1995) and documenting consultations (Weed, 1968) do not provide much structure or support for collaborative decision making. As providers try to accommodate patients' preferences for involvement and information, they need more support and better tools to engage patients in decisions about treatment.

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A growing field of research is dedicated to filling the decision gap. Many researchers have focused on creating decision support interventions, called decision aids, for patients. Decision aids provide information about the benefits and harms of different choices and may provide exercises to help patients express their values or worksheets for patients to bring to their physicians (Llewellyn-Thomas, 1995). Decision aids have been developed and evaluated in specific oncology decisions such as surgery and adjuvant therapy for patients newly diagnosed with breast cancer (Chapman, Elstein, & Hughes, 1995; Goel, Sawka, Thiel, Gort, & O'Connor, 2001; Gramlich & Waitzfelder, 1998; Maslin, Baum, Walker, A'Hern, & Prouse, 1998; O'Connor, Fiset, et al., 1999; O'Connor, Rostom, et al., 1999; Whelan et al., 1999), screening for prostate cancer (Frosch, Kaplan, & Felitti, 2001), and treatment for a new diagnosis of prostate cancer (Frosch et al.; Onel et al., 1998). However, decision aids are not easy to translate into clinic settings. Some are not available publicly, others are costly to purchase, and many are out of date (O'Connor et al., 2001).

To help address these issues, the authors present two new tools, the Consultation Planning Template (CPT) and Consultation Recording Template (CRT), which nurses can use to help patients prepare for and summarize their consultations. The templates are simple to use, only require a computer to modify, and can be adapted to different decisions. Nurses are the logical facilitators for these tools because, in many clinics, much of the responsibility for educating patients and helping patients prepare for decision making falls on nurses.

## Consultation Planning Template

The CPT consists of a structured outline that prompts patients to generate decision-focused agendas for their meetings with healthcare providers. The CRT consists of a structured outline that prompts patients and providers (or, ideally, facilitators acting on their behalf) to create written summaries of consultations.

The main sections of both templates include **Process Issues, Diagnosis and Prognosis, Treatment Choices, Treatment Implications, Values and Preferences, and Next Steps**. The order and content of the sections reflect theories of effective meeting management and decision making (Doyle & Straus, 1982; Hammond, Keeney, & Raiffa, 1998; Howard & Matheson, 1989; Llewellyn-Thomas, 1995). In each section, subtopics can be tailored to the clinical setting where the template is being used.

Trained facilitators (this role can be fulfilled by nurses, patient navigators, or resource center staff members) use the CPT as a guide to elicit and record patients' questions and concerns for upcoming medical consultations. Table 1 contains a CPT with prompts that are illustrative of those used for breast cancer consultations (and may be applicable to other cancers as well). The result is a Consultation Plan that may be formatted as a table, structured outline, or flowchart (see Table 2).

During consultation planning sessions, facilitators use the focused questions from the CPT, as well as open-ended follow-up questions, to elicit patients' agendas for medical visits. Then, facilitators organize and format the agenda to produce a Consultation Plan. During the session, facilitators do not provide medical information, but they focus on eliciting and organizing what the patients know and the key questions

they have. The authors have trained volunteers and resource center staff without medical backgrounds to implement the CPT effectively. Nurses who use the CPT as part of their interaction with patients often separate the role of facilitator by dedicating some time to elicit patients' questions and concerns (perhaps 10–15 minutes) before attempting to answer the questions or correct any misconceptions.

One type of implementation is illustrated by the following case study, which was adapted from an interaction at the University of California, San Francisco (UCSF) Breast Care Center (BCC). Certain personal and medical information was changed to protect patient confidentiality. The consultation planner and recorder at BCC is a sociologist, and the services are offered free of charge to patients.

### Case Study Part I: Consultation Planning

Ms. Jones was in her mid-40s, a single mother with a nine-year-old daughter and a busy career as an attorney. A recent biopsy had shown invasive ductal carcinoma, and she was about to meet with the surgical oncologist to review her treatment decision. She came an hour before her appointment to meet with a consultation planner and recorder. The goal of the session was to elicit, capture, and organize her questions and concerns for her upcoming appointment.

The consultation planner started the session by probing into items associated with **Process Issues**. When asked what her goal was for the upcoming appointment, Ms. Jones replied, "I'm confused by the medical terminology used to describe cancer and overwhelmed with the amount of information I have read. My biggest priority is to clearly understand what my options are. And then to schedule a surgery as soon as possible, so that I can rearrange other aspects of my life—my work and child care."

They spent the next five minutes talking through Ms. Jones' questions and concerns about her **Diagnosis and Prognosis**. The consultation planner summarized the discussion with the general inquiry, "Can you explain more about the diagnosis?" and the more specific questions, "What is the difference between hormone receptor-positive and -negative cancers?" and "What is the difference between grading and staging?" The planner probed further about how the information might affect her decision about treatment; Ms. Jones responded that she wanted to know how urgent the situation was so that she could know how aggressive to be.

Then the planner focused on Ms. Jones' questions and concerns about **Treatment Choices**. Ms. Jones had read that the main options for breast cancer were mastectomy or lumpectomy with radiation, but she wondered if other treatments were available. During the discussion about **Values and Preferences**, Ms. Jones felt very strongly that a mastectomy would have a negative effect on her sense of identity and body image and that she would prefer to undergo a lumpectomy, if possible. The planner summarized this with the notations, "This is not about how I look to the world; this is how I feel about myself" and "My breasts are an important part of my identity." To probe the strength of her preferences, the planner then asked Ms. Jones the circumstances under which she would consider a mastectomy. Ms. Jones thought for a moment and said that if a mastectomy would make a big difference in whether or not she survived breast cancer, then she would choose a mastectomy. "Bottom line, I want to live, and I want to be around for my kid; that's the most important thing to me."

**Table 1. Consultation Planning Template With Sample Prompts**

Section	Topic Areas	Examples of Facilitator Prompts
Process Issues	Goal for the consultation Desired participation	What do you want to have accomplished when you leave the consultation? If decisions need to be made, do you want to make them, should the doctor make them, or do you want to make them together?
	Timeline	How much time can you safely take for decision making before beginning treatment?
Diagnosis and Prognosis	Test results	Do you have copies of your pathology report? What questions do you have about your diagnosis?
	Further testing	Have you had a second opinion? Are you aware of any other tests that would provide important information for upcoming decisions?
	Baseline prognosis	Do you wish to know your prognosis (e.g., survival rate) assuming you have no further treatment beyond the absolute minimum?
Treatment Choices	Treatment spectrum	What are three treatment options: An aggressive choice, a minimally invasive choice, and one in between?
	Complementary therapy	Are you considering or currently pursuing any complementary therapies? What kinds?
	Treatment interactions	Can any interactions occur between past, present, and future treatments, both medical and complementary?
Treatment Implications	Benefits and harms	What are the benefits? What is the 10-year risk of recurrence and 10-year survival rate? What are the harms? How common are the side effects?
	Impact on daily life	For the options you are evaluating, what are the quality-of-life implications (e.g., for hobbies, work, relationships, body image)?
	Ranking the treatments	What treatment are you leaning toward and why? What do you need to clarify in order to rank your treatment options?
Values and Preferences	Tradeoffs	Which benefits are most important? Which harms do you want to avoid? Which are more important, the benefits or harms?
	Treatment goals, hopes, and fears	What do you hope to achieve through treatment? Do you have any other hopes or fears concerning your treatment options? What are your expectations for each treatment?
	Thoughts and feelings	Do you have any thoughts and feelings you are hesitant to express? Why?
Next Steps	Treatment selection	Which choice is best? What other issues need to be resolved?
	Action items	Who needs to do what, and by when?
	Barriers and resources	What resources can help you overcome barriers to achieving the next steps?

When Ms. Jones felt confident that all of her questions and concerns had been captured, the planner moved on to **Next Steps**, asking Ms. Jones what she needed to begin treatment. Reiterating her second priority, Ms. Jones said that surgery would involve making arrangements for child care and with her work. She needed to take care of the areas in her life that might be disrupted by surgery, so having a realistic picture of what the treatments involved and recovery time, as well as a definite date, would help her plan and get organized. Then the planner gave Ms. Jones a copy of the plan and asked her to rehearse talking through the plan, as if she was actually talking to her physician. The planner made a few more changes to better reflect how Ms. Jones actually raised the questions in the rehearsal and then printed out several copies of the Consultation Plan. The planner gave one to Ms. Jones and attached one to her medical chart for the physician to see. The session lasted 35 minutes.

## Consultation Recording Template

The CRT follows the same general structure outlined in the CPT: **Process Issues, Diagnosis and Prognosis, Treatment Choices, Treatment Implications, Values and Preferences,**

**and Next Steps.** Therefore, the CRT complements the CPT and helps patients get their questions and concerns addressed. The CRT is used during the medical consultation to structure the conversation and capture the important information needed for decision making.

CRTs have been created for the following four decisions: treatment of ductal carcinoma in situ, surgical treatment for early-stage invasive breast cancer, breast reconstruction, and adjuvant therapy for early-stage invasive breast cancer. Each reflects the unique situation for each decision. The specific decision and the amount of information included in the record (e.g., probabilities of good and bad outcomes, descriptions of treatments) can be adapted to fit the providers' needs and match clinic practice. Other breast cancer CRTs under development address decisions about treatment of metastatic disease and prevention for women at high risk.

Nurses can use the CRT to structure and record their visits with patients. The following case study continues the illustration of how these templates are used at BCC. The consultation planner and recorder accompanied the patient to the visit with the physician and used the CRT to record the consultation.

**Table 2. Sample Completed Consultation Plan: Meeting With a Surgical Oncologist**

Section	Topic Areas	Ms. Jones' Questions and Concerns
Process Issues	Goal for the consultation	My biggest priority is to clearly understand what my options are and schedule surgery as soon as possible.
	Desired participation	I want to share decision making with my doctor.
	Timeline	I want to schedule surgery as soon as possible so that I can rearrange other aspects of my life (i.e., work and child care).
Diagnosis and Prognosis	Clarification of test results	The biopsy showed invasive ductal carcinoma. Can you explain more about my diagnosis? What is the difference between hormone receptor-positive and -negative cancers? What is the difference between grading and staging?
	Further testing	What is my hormone receptor status? When will I find that out? Overall, I want to know how urgent the situation is so I know how aggressive to be.
Treatment Choices	Treatment spectrum	I have read that my options are mastectomy or lumpectomy plus radiation. Do any others exist?
Treatment Implications	Benefits and harms	If I chose a lumpectomy, what are the risks? What is my chance of survival with each choice?
	Impact on daily life	I need to make arrangements for child care and with my work. I am a single mother; I have a nine-year-old and a busy job.
	Ranking the treatments	I am leaning toward lumpectomy. If a mastectomy would make a big difference in whether or not I survived, I would choose a mastectomy.
Values and Preferences	Treatment goals	Bottom line, I want to live, and I want to be around for my kid; that's the most important thing to me.
	Thoughts and feelings	This is not about how I look to the world—this is about how I feel about myself. My breasts are an important part of my identify.
Next Steps	Action items	I need to take care of other aspects of my life that might be disrupted by surgery, so having a realistic picture of what the treatments involve and recovery time, as well as a definite date, would help me plan and get organized.

## Case Study Part II: Consultation Recording

The planner met with the physician as he flipped through Ms. Jones' chart and briefly went over the Consultation Plan. They entered the examination room where Ms. Jones was waiting, and the planner began by reviewing some of the **Process Issues** such as discussing goals, the agenda, and the time available. The physician proposed, "What I'd really like to do now is examine you, then talk about the diagnosis and what we know so far about your cancer. Then we can talk about the different treatment choices and how you feel about them. Hopefully by the end of the visit we will have settled on a decision, but if we don't, that's okay, too. You have some time to think about this. I know from your Consultation Plan that you are anxious to schedule surgery, and we can go ahead and schedule surgery, but I want to make sure that you know that medically we do not have to rush; you can take a few weeks to make the decision."

As the visit progressed, the planner recorded the discussion, editing the CRT on a laptop computer. The physician spent time explaining the **Diagnosis and Prognosis** and **Treatment Choices and Implications**. The planner periodically facilitated the conversation, asking open-ended questions to make sure Ms. Jones was following the discussion, such as, "What do you understand about the treatment choices so far?"

During the discussion about **Values and Preferences**, Ms. Jones shared her feelings about a mastectomy. "I just think it will negatively impact my sense of identity and body image," she said. The physician then took some of the struc-

tured questions on the CRT to probe Ms. Jones' preferences further: "You realize that with the lumpectomy and radiation, you will be taking on the added risk that the cancer will come back in the breast that you keep. How do you feel about that?" Ms. Jones replied, "Obviously I don't want to have to deal with this again, but you said the survival was the same, so if it does come back, I'll have a mastectomy then." The physician also explained breast reconstruction and showed Ms. Jones some pictures to see if that might help remove some of her concerns associated with mastectomy.

Satisfied that they were converging on a decision, the physician said, "It seems like we have our decision; how does it seem to you?" Ms. Jones replied, "I think so, too. I know that I might have an increased risk of cancer coming back in the breast, but if survival is the same, I'd rather keep my breast. The reconstruction is much better than I expected, but I can't afford to be out of work and recuperating for that long."

The planner reiterated, "So we are agreed to try a lumpectomy with radiation," and then suggested they clarify the **Next Steps**. At the end of the consultation, the planner printed out several copies of the record, then gave one to Ms. Jones and the other to the physician (see Table 3). Before she and the planner left, they reviewed the record and made sure that the important points were covered. Ms. Jones met with the surgery scheduler on the way out and made an appointment for surgery. The consultation lasted 45 minutes.

**Table 3. Sample Completed Consultation Record**

Section	Topic Areas	Results for Ms. Jones
Process Issues	Goal for the consultation	Ms. Jones clearly understands her options and wants to schedule surgery as soon as possible.
	Desired participation Agenda and timeline	Ms. Jones wants to share decision making with the doctor. See Consultation Plan for agenda. We can schedule surgery as soon as next week, but medically we do not need to rush the decision.
Diagnosis and Prognosis	Physical examination	Site is healing well.
	Results of biopsy	
	Tumor size	About 1.8 cm
	Tumor type	Invasive ductal carcinoma
	Size of margin	Most > 1 cm; deep margin only 2 mm
	Hormone receptors	Estrogen receptor-positive and progesterone receptor-positive
	Aggressiveness	Moderately differentiated
	Prognosis and comments	Because deep margin is close, the doctor recommends more surgery. Most of the results are favorable; it is not too big and not too aggressive.
Treatment Choices	Lumpectomy with radiation	Removing the deep margin may cause some slight deformity. Radiation is every day for five or six weeks.
	Mastectomy	Removal of entire breast with or without immediate reconstruction, either implant or expander or flap procedure
	Comments	Ms. Jones is a good candidate for either. She should consider sentinel node biopsy. The doctor may not get clear margins (about a 20% chance), and she might need another re-excision or mastectomy.
Treatment Implications	Benefits and harms	
	Survival	Same with either choice
	Chance of cancer coming back	Lumpectomy and radiation: 10%–15% chance of cancer coming back in breast she saves over the next 10 years.
	Side effects and complications	Lumpectomy and radiation may cause more deformity of breast. Radiation can cause fatigue and skin changes (e.g., redness, thickening, blisters). Mastectomy includes loss of breast and the need to decide whether to have immediate reconstruction.
	Impact on daily life	Surgery can be scheduled for next week. If she wants reconstruction, surgery probably will not happen until three weeks (next available slot). With reconstruction, recovery will take longer.
	Ranking the treatments	Ms. Jones wants to make sure this does not come back but would like to keep her breast if she can. She does not mind a little deformity; it seems better than going through reconstruction.
Values and Preferences	How important is	On a scale of 0–3, with 0 being not important and 3 being most important
	Keeping your breast?	0      1      2      ③
	Minimizing chance of cancer coming back?	0      1      ②      3
	Avoiding radiation?	①      1      2      3
Next Steps	Treatment selection	Lumpectomy and radiation
	Action items	1. Before leaving, Mrs. Jones will schedule surgery for next Tuesday or Wednesday. 2. Ms. Jones will meet with a nurse the day before surgery to review preoperative procedures and discuss lymph node surgery. 3. If surgery is Tuesday or Wednesday, the preliminary report should be ready by Friday afternoon. The doctor will call her at home after 5 pm with the results.

The templates can be modified to reflect individual cases, subtopics can be deleted if they do not apply, and others can be added. For example, if a patient has concerns about family history and is considering a bilateral mastectomy, this can be added in the **Treatment Choices**.

The templates were developed and evaluated for use with breast cancer. However, the structure is generic and can be used for other cancers. For example, staff members at the UCSF Cancer Resource Center have modified the CPT for

patients with other cancers, including gallbladder, brain, prostate, pancreatic, and ovarian.

## Evaluation Results

Early forms of the CPT were tested in clinical trials (n = 20, n = 97, n = 24) at a community resource center and two tertiary care breast centers (Belkora, 1997; Sepucha et al., 2002; Sepucha, Belkora, Tripathy, & Esserman, 2000). Patients in the

trials were diagnosed with breast cancer and scheduled to see either a surgical or medical oncologist to discuss decisions about surgery, adjuvant therapy, treatment for local recurrence, and metastatic disease.

In the main trial of consultation planning (Sepucha et al., 2002), patients were assigned to one of two visit preparation interventions before their appointments. In the first, Productive Listening, a researcher spent 20 minutes asking each patient to talk about their experiences communicating with physicians. In the second, Consultation Planning, a researcher spent 20 minutes eliciting each patient's questions and concerns and organized them into printed agendas. Sixty-four percent of patients reported three or more barriers to communication, such as information overload, not knowing who to see about their concerns, and not knowing what questions to ask. Both interventions provided a significant reduction in communication barriers. Physicians were significantly more satisfied with patients who had prepared using Consultation Planning. They believed those patients had a better understanding of the choices and issues surrounding their cases. Consultation Planning was significantly more satisfying to patients than Productive Listening sessions.

Early versions of the CRT were tested in a pilot study ( $n = 24$ ) comparing CPT alone with CPT plus CRT (Sepucha et al., 2000). The study found that patients with breast cancer were confused about decisions. Fewer than 20% reported that they knew which choice was best before the consultation. When used together, the CPT and CRT significantly increased the quality of decisions and proved to be more satisfying to patients and physicians than the CPT alone. The study also measured the quality of communication by comparing responses from patients and physicians to similar questions, such as, "It is clear which treatment is best." If they both agreed (or both disagreed), then they had a higher level of understanding than if one agreed and the other disagreed. The study found that the CPT and CRT significantly increased the level of shared understanding between patients and physicians when compared to CPT alone. The CRT accomplished this without lengthening visits.

Given the positive results, clinicians and researchers at BCC started the Program for Collaborative Care to provide the services to all of their patients. The program is funded through grants and supports a full-time manager, who provides the services.

During the past two years, the manager has used the tools with more than 500 patients. In addition, the authors have trained more than 30 nurses, volunteers, and staff members at community cancer resource centers to use the templates with patients in their organizations.

To date, the evaluations have been rather small trials, exclusively in breast cancer. A multicenter clinical trial is being developed to more formally evaluate the effects of the templates on the quality of decisions made by patients with breast cancer in collaboration with their providers. In addition, a pilot study is under way to evaluate whether similar tools can address the communication and decision-making needs of women with metastatic breast cancer. Other studies should explore how well the structure works with different cancers, with different patient populations (such as men with prostate cancer), and in nurses' interactions with patients.

## Benefits of Using the Tools in Practice

Encouragement from nurses or other healthcare providers is an important factor in enabling patients to participate in decisions (Sainio, Eriksson, & Lauri, 2001). The CRT and CPT provide a practical way to include patients in the decision-making process.

Current best practices used by nurses to engage patients have some problems. One common practice is encouraging patients to make a list of questions. However, this often results in patients having pages of questions that may or may not be relevant to the decisions at hand. For example, in preparation for a visit with a surgeon, a patient may create an extensive list of questions about chemotherapy and hair loss, but the healthcare team will not know until after surgery results come back whether chemotherapy is a reasonable option. The CPT helps nurses focus and organize patients' thoughts on issues that are relevant to the next decision they face.

Another common practice is providing a list of frequently asked questions. These can be helpful but often are lengthy and not prioritized, and they may not contain the issues that concern particular patients. The CPT allows nurses to efficiently help patients express what is on their minds.

Providers do not always elicit or address their patients' agendas during medical consultations (Marvel et al., 1999). The CPT helps do this in a systematic way. Reviewing patients' agendas can help nurses understand the context in which patients are operating, which is important for quality decisions (Schaefer, Ladd, Gergits, & Gyauch, 2001; Steginga, Occhipinti, Wilson, & Dunn, 1998). With the Consultation Plan, nurses can determine quickly whether patients' expectations are realistic and when more information is needed. This enables nurses to tailor conversations to patients' agendas, making more efficient and effective use of limited time.

The CRT enables providers—both nurses and physicians—to document critical consultations when treatment decisions are discussed and provides patients with breast cancer with understandable answers to their specific questions and concerns. Patients feel relieved that they do not need to remember everything because a record has been created, and they like being able to take it home and share it with family and others.

With the templates, nurses can be more confident that the information patients take away is an accurate reflection of what transpired. The templates also provide better documentation, which can speed the dictation process and free nurses' time for patient care activities (Skinn & Stacey, 1994).

Having a record also can help coordinate care among different providers. Patients may see physicians first, then follow up with nurses (or vice versa). Having documents that summarize what happened with physicians can help nurses determine where they might focus their time, likewise for physicians who see patients after nurses do.

## Special Issues

The case study presented in this article reflects one implementation of the templates. Consultation planning has been implemented in two university breast clinics, six community cancer resource centers, and one hospital-based cancer resource center. A phone survey of current users indicated that nurses who were implementing the tools believed that they were very valuable, but many struggled to find time in their schedules to

use the tools with the many patients who could benefit from them. As a result, in each setting, nurses, clinic staff, or volunteers have adapted the methods to fit their needs and resource constraints. The sessions range from 15 minutes (in the breast clinics, facilitated by nurses) to an hour and a half (in the community resource centers, facilitated by trained volunteers). In one clinic, nurses use the CPT not in a separate session, but as part of their assessments of patients' needs at the beginning of their consultations. Another facilitator works with patients via telephone and mails or faxes completed Consultation Plans. Application of the tools is considerably flexible, and training materials are available from the authors.

Consultation planning prompts patients to prepare for consultations at which they will discuss decisions collaboratively with their care providers. The objective is to provide just enough structure to help patients prepare for decisions without dictating the content of the agenda, which must reflect each patient's uniqueness. This delicate balance challenges nurses to focus on eliciting patients' agendas before yielding to the natural temptation to begin answering questions and providing information. The skills necessary for eliciting patients' agenda include listening, low-inference paraphrasing, and productive questioning skills familiar to nurses with counseling backgrounds.

Patients have had an overwhelmingly positive reaction to facilitators during consultations; however, physicians at UCSF have had mixed reactions to the presence of another person in consultations. Over time, however, most physicians have found value in the CRT. One physician, who initially expressed no desire to use the methods, incorporated them one year later into her practice and uses the templates to dictate her notes.

Obviously, hiring a person dedicated to filling this role is not practical for most clinics. Several opportunities exist to fill the role with trained volunteers, medical or nursing students, or other researchers, which may make implementation more practical in different settings (Laughlin, 1999). Currently, research is under way to develop a Web-based version of the CPT that patients could self-administer. The prototype has not been tested with patients; also, whether computers can provide similar help as personal contact is unclear. In addition, researchers

plan to explore the effectiveness of having providers, patients, family members, or friends who accompany patients to visits use the CRT without a facilitator to record discussions.

## Conclusion

The medical consultation is an important meeting but not often thought of as a meeting by patients, nurses, or physicians. Most large corporations have adopted best practices that make meetings run more effectively. For example, standard procedures include creating an agenda, having someone facilitate the meeting, agreeing on a process for decision making, and having someone record the meeting and distribute the summary to all participants (Doyle & Straus, 1993).

Although such procedures make sense, they are uncommon in practice and virtually nonexistent in the medical consultation. Patients with breast cancer often arrive unprepared, rarely know when consultations will actually start, usually have no idea how long they will last, do not know the agenda or their role in the decision-making process, and do not get a record of the meeting. These critical meetings, where important decisions are made, need help. The CPT and CRT are designed to improve the quality of decisions and have proven to be adaptable to a variety of clinical settings.

Patients are demanding more involvement in decisions about their care. To respond to this shift, nurses need practical tools to help encourage patient participation and, at the same time, support high-quality decisions. The tools presented in this article provide a practical way to engage patients in the decision-making process. The templates provide a structure for consultations and can help patients prepare their questions and concerns, as well as record the answers.

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## References

- Belkora, J. (1997). Mindful collaboration: Prospect mapping as an action research approach to planning for medical consultations. Doctoral dissertation, Stanford University, Stanford, CT. *Dissertation Abstracts International*, 58(09), 4703. (UMI No. 9810081)
- Berland, G.K., Elliott, M.N., Morales, L.S., Algazy, J.I., Kravitz, R.L., Broder, M.S., et al. (2001). Health information on the Internet: Accessibility, quality, and readability in English and Spanish. *JAMA*, 285, 2612–2621.
- Chapman, G.B., Elstein, A.S., & Hughes, K.K. (1995). Effects of patient education on decisions about breast cancer treatments: A preliminary report. *Medical Decision Making*, 15, 231–239.
- Cimprich, B., & Ronis, D.L. (2001). Attention and symptom distress in women with and without breast cancer. *Nursing Research*, 50, 86–94.
- Doyle, M., & Straus, D. (1993). *The new interaction method: How to make meetings work*. New York: Berkeley Publishing Group.
- Frosch, D.L., Kaplan, R.M., & Felitti, V. (2001). The evaluation of two methods to facilitate shared decision making for men considering the prostate-specific antigen test. *Journal of General Internal Medicine*, 16, 391–398.
- Goel, V., Sawka, C.A., Thiel, E.C., Gort, E.H., & O'Connor, A.M. (2001). Randomized trial of a patient decision aid for choice of surgical treatment for breast cancer. *Medical Decision Making*, 21, 1–6.
- Gramlich, E.P., & Waitzfelder, B.E. (1998). Interactive video assists in clinical decision making. *Methods of Information in Medicine*, 37, 201–205.
- Hammond, J., Keeney, R., & Raiffa, H. (1998). *Smart choices: A guide to making better decisions*. Cambridge, MA: Harvard Business School Press.
- Howard, R.A., & Matheson, J.E. (Eds.). (1989). *Readings on the principles and applications of decision analysis*. (Vols. I & II). Menlo Park, CA: Strategic Decisions Press.
- Laughlin, J. (1999, January 2). Tagging along: Getting an education by taking notes for ER doctors, premed "scribes" get a jump on medical school. *The Washington Post*, pp. B3.
- Lipkin, M.J., Putnam, S.M., & Lazare, A. (Eds.). (1995). *The medical interview: Clinical care, education, and research*. New York: Springer-Verlag.
- Llewellyn-Thomas, H.A. (1995). Patients' health-care decision making: A framework for descriptive and experimental investigations. *Medical Decision Making*, 15, 101–106.
- Lobb, E.A., Butow, P.N., Kenny, D.T., & Tattersall, M.H. (1999). Communicating prognosis in early breast cancer: Do women understand the language used? *Medical Journal of Australia*, 171, 290–294.
- Marvel, M.K., Epstein, R.M., Flowers, K., & Beckman, H.B. (1999). Soliciting the patient's agenda: Have we improved? *JAMA*, 281, 283–287.
- Maslin, A.M., Baum, M., Walker, J.S., A'Hern, R., & Prouse, A. (1998). Using an interactive video disk in breast cancer patient support. *Nursing Times*, 94(44), 52–55.

- O'Connor, A., Stacey, D., Rovner, D., Holmes-Rovner, M., Tetroe, J., Llewellyn-Thomas, H., et al. (2001). Decision aids for people facing health treatment or screening decisions [Cochrane Review]. *The Cochrane Library*, 3. Oxford, England: Update Software.
- O'Connor, A.M., Fiset, V., DeGrasse, C., Graham, I.D., Evans, W., Stacey, D. et al. (1999). Decision aids for patients considering options affecting cancer outcomes: Evidence of efficacy and policy implications. *Journal of the National Cancer Institute. Monographs*, 25, 67–80.
- O'Connor, A.M., Rostom, A., Fiset, V., Tetroe, J., Entwistle, V., Llewellyn-Thomas, H., et al. (1999). Decision aids for patients facing health treatment or screening decisions: Systematic review. *BMJ*, 319, 731–734.
- Onel, E., Hamond, C., Wasson, J.H., Berlin, B.B., Ely, M.G., Laudone, V.P., et al. (1998). Assessment of the feasibility and impact of shared decision making in prostate cancer. *Urology*, 51, 63–66.
- Rees, C.E., & Bath, P.A. (2001). Information-seeking behaviors of women with breast cancer. *Oncology Nursing Forum*, 28, 899–907.
- Roter, D.L., & Hall, J.A. (1987). Physician's interviewing styles and medical information obtained from patients. *Journal of General Internal Medicine*, 2, 325–329.
- Sainio, C., Eriksson, E., & Lauri, S. (2001). Patient participation in decision making about care. *Cancer Nursing*, 24, 172–179.
- Schaefer, K.M., Ladd, E., Gergits, M.A., & Gyauch, L. (2001). Backing and forthing: The process of decision making by women considering participation in a breast cancer prevention trial. *Oncology Nursing Forum*, 28, 703–709.
- Sepucha, K. (1999). Consultation recording methods to facilitate collaborative decision-making in breast cancer. Unpublished doctoral dissertation, Stanford University, Stanford, CA. *Dissertation Abstracts International*, 60(04), 1511. (UMI No. 9924548)
- Sepucha, K.R., Belkora, J.K., Mutchnick, S., & Esserman, L.J. (2002). Consultation planning to help patients prepare for medical consultations: Effect on communication and satisfaction for patients and physicians. *Journal of Clinical Oncology*, 20, 2695–2700.
- Sepucha, K.R., Belkora, J.K., Tripathy, D., & Esserman, L.J. (2000). Building bridges between physicians and patients: Results of a pilot study examining new tools for collaborative decision making in breast cancer. *Journal of Clinical Oncology*, 18, 1230–1238.
- Skinn, B., & Stacey, D. (1994). Establishing an integrated framework for documentation: Use of a self-reporting health history and outpatient oncology record. *Oncology Nursing Forum*, 21, 1557–1566.
- Steginga, S., Occhipinti, S., Wilson, K., & Dunn, J. (1998). Domains of distress: The experience of breast cancer in Australia. *Oncology Nursing Forum*, 25, 1063–1070.
- Suchman, A.L., Markakis, K., Beckman, H.B., & Frankel, R. (1997). A model of empathic communication in the medical interview. *JAMA*, 277, 678–682.
- Weed, L.L. (1968). Medical records that guide and teach. *New England Journal of Medicine*, 278, 652–657.
- Whelan, T., Levine, M., Gafni, A., Sanders, K., Willan, A., Mirsky, D., et al. (1999). Mastectomy or lumpectomy? Helping women make informed choices. *Journal of Clinical Oncology*, 17, 1727–1735.
- White, J., Levinson, W., & Roter, D. (1994). "Oh, by the way ...": The closing moments of the medical visit. *Journal of General Internal Medicine*, 9(1), 24–28.

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[www.nabco.org](http://www.nabco.org)
- ▶ Susan G. Komen Breast Cancer Foundation  
[www.komen.org](http://www.komen.org)
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