

## Recording Physician-Patient Visits: Minimal Cost, Minimal Gain

Hack TF, Pickles T, Bultz BD, et al. Impact of providing audiotapes of primary adjuvant treatment consultations to women with breast cancer: a multisite, randomized, controlled trial. *J Clin Oncol* 2003;21:4138-44.

### Study Overview

**Objective.** To examine the impact of providing newly diagnosed breast cancer patients with an audiotape of their initial adjuvant treatment consultation.

**Design.** Double-blind randomized, controlled trial.

**Setting and participants.** 628 women newly diagnosed with breast cancer presenting for their initial adjuvant treatment consultation and 40 oncologists (medical and radiation) from 6 cancer centers in Canada. Patients were randomized to 1 of 4 groups: standard care, not audiotaped (C); audiotaped, not given audiotape (T1); audiotaped, given audiotape (T2); and audiotaped, offered choice of receiving tape (T3). Consultations were recorded simultaneously for all treatment patients on 2 recorders placed at a predetermined location in the room. The physical examination was not recorded. A nurse met with each patient after the consultation to administer the postconsultation measures (ie, Control Preferences Scale and Patient Perception Scale). Subsequently, the patient's treatment group assignment was revealed. A nurse contacted each patient by telephone 12 weeks postconsultation and completed the following assessments: the Control Preferences Scale, Patient Perception Scale, Audiotape Use and Satisfaction Questionnaire, Informed Communication Scale, Profile of Mood States, and Functional Assessment of Cancer Therapy.

**Main outcome measures.** Perceived degree of information provision, audiotape satisfaction and use, communication satisfaction with oncologist, mood state, and cancer-specific quality of life.

**Main results.** There were no statistically significant differences in demographic or treatment variables across groups. 323 patients received an audiotape, and of these, 196 (60.7%) listened to at least a portion of the audiotape during the 12-week postconsultation period, whereas 127 (39.3%) patients did not. Patients listened to the entire tape an average of 2.2 times and a portion of the tape 2.5 times. Of patients who received the audiotape, 134 (41.5%) had someone other than (or in addition to) themselves listen to at least a portion of the tape. The average number of other persons

who listened to the audiotape was 2.1. A comparison of the 2 groups who received a copy of the audiotape (T2 and T3) with the 2 groups who did not receive the audiotape (T1 and C) revealed no significant differences in the following 12-week postconsultation outcomes: patient satisfaction with communication with the oncologist, mood state, or quality of life. An examination of the impact of the audiotaping process (C versus T1) also produced no statistically significant differences on any of these outcomes. Patients who received the audiotape reported having been provided with significantly more information about the side effects of treatment and had significantly better recall of having discussed side effects than patients who did not receive the audiotape. Audiotape benefit was not significantly related to patient satisfaction with communication, mood state, or quality of life at 12 weeks postconsultation and was not significantly affected by choice of receiving the audiotape. Patients rated the audiotape intervention positively, with an average score of 83.9 out of 100.

**Conclusion.** Audiotape provision benefits patients by facilitating their perception of being informed about treatment side effects but does not significantly influence patient satisfaction with communication, mood state, or quality of life.

### Commentary

Initial consultations after a new diagnosis of cancer can be daunting for patients and their families. These encounters often involve large amounts of information concerning the diagnosis, evaluation, and treatment options. Patients may leave these initial visits confused and overwhelmed with the amount and complexity of new information. Improving how this information is communicated between physicians and patients can enhance patient satisfaction and care [1,2].

Audiotapes and letters have been used to help enhance communication between oncologists and patients; however, studies examining the usefulness of such aids have had mixed results. Hack and colleagues conducted a large randomized trial looking at the impact of audiotapes used in initial consultations for patients with new cancer diagnoses. The study was well-designed and controlled by using 4 cohorts that helped to account for dual variables (the audiotaping process and the tape itself) in terms of outcomes. The authors found

that neither the taping process nor the tapes themselves significantly impacted measured outcomes of patient satisfaction or quality of life, although the majority rated the intervention positively. The tapes helped patients perceive themselves as being better informed, particularly with regard to treatment side effects. It is not clear if patients sought other sources of information (eg, second opinions, Web-based resources) that may have negated any true benefit of audiotapes. As well, it is possible that the instruments used did not capture other subjective benefits of the tapes that may account for the overall positive rating by patients. Finally, it is worth noting that the tapes had essentially no negative impact on patients and are relatively inexpensive communication aids.

### **Applications for Clinical Practice**

Audiotapes are easy and practical tools that can enhance physician-patient communication. Audiotapes help some patients with cancer feel more informed but do not appear to impact quality of life.

—Review by David R. Spigel, MD

### **References**

1. Lee SJ, Back AL, Block SD, Stewart SK. Enhancing physician-patient communication. *Hematology (Am Soc Hematol Educ Program)* 2002;464–83.
2. Smith TJ. Tell it like it is. *J Clin Oncol* 2003;21(9 Suppl):12–6.

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## **Impact of Nonphysician Coaching on Cardiovascular Risk Factors in Patients with Coronary Heart Disease**

Vale MJ, Jelinek MV, Best JD, et al. Coaching patients On Achieving Cardiovascular Health (COACH): a multicenter randomized trial in patients with coronary heart disease. *Arch Intern Med* 2003;163:2775–83.

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### **Study Overview**

**Objective.** To determine if frequent communication with dietitian or nurse coaches who did not prescribe medication led to reductions in cardiovascular risk factors among adults with coronary artery disease (CAD).

**Design.** Randomized controlled trial.

**Setting and participants.** Adults from 6 medical centers in Melbourne, Australia, with CAD were recruited during hospitalizations for coronary artery bypass surgery, percutaneous coronary intervention, acute myocardial infarction, or coronary angiography with planned revascularization. Patients who could not be reached by phone, did not speak English, did not have a fasting blood sample done in the first 24 hours of hospitalization, were participating in another study, could not return to the hospital for follow-up, or were judged too ill to participate were excluded.

**Intervention.** Patients were randomized to receive a coaching intervention or usual care. The intervention consisted of information on their in-hospital cardiac risk factors, a list of risk factor targets, and a series of telephone calls and written follow-up from the coaches. The goal of coaching was to encourage patients to go to their regular physicians to obtain

measurements of cardiac risk factors and negotiate a plan for reaching risk factor targets (ie, total cholesterol < 155 mg/dL, smoking cessation, fasting glucose < 110 mg/dL, body mass index < 25 kg/m<sup>2</sup>, saturated fat intake of < 10% of total energy intake, and at least 30 minutes of moderate-intensity physical activity on most days of the week). Patients received 4 coaching telephone calls at 6-week intervals and were mailed printed reports after the phone conversations.

**Main outcome measures.** Outcomes were measured after 6 months. The primary outcome was change in fasting serum total cholesterol. Secondary outcomes included change in triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein (LDL) cholesterol; systolic and diastolic blood pressure; body weight; body mass index; fasting glucose; dietary intake of saturated fat, cholesterol, and fiber (using a food frequency questionnaire); smoking (using serum cotinine level); and depression and anxiety (using validated scales).

**Main results.** Total cholesterol was 14 mg/dL lower in the intervention group (95% confidence interval, 8–20 mg/dL). The intervention group also had significantly better results for LDL cholesterol (13 mg/dL), body weight (0.9 kg), and blood pressure (4.4/2.4 mm Hg) (all  $P \leq 0.005$ ). Self-reported anxiety, saturated fat intake, dyspnea, and chest pain also

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