Recordings or summaries of consultations for people with cancer (Review)

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Recordings or summaries of consultations for people with cancer

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ABSTRACT

Background

Many people find it difficult to remember information provided during medical consultations. One way of improving this may be to provide a record of the conversation.

Objectives

This review examined the effects of providing recordings or summaries of their consultations to people with cancer and their families.

Search methods

We searched the following sources: The Cochrane Library (issue 2 2007); MEDLINE (1966 to 29 May 2007); CINAHL (1982 to 29 May 2007); Dissertation Abstracts (1861 to 29 May 2007; Index to Theses 29 May 2007; EMBASE (1985 to 29 May 2007); PsycINFO (1967 to 29 May 2007); AMED (1985 to 29 May 2007); British Nursing Index (1985 to May 2007); SCI-EXPANDED, SSCI (1986 to 3 June 2007); and Sociological Abstracts (1998 to 29 May 2007). For the initial (1999) publication of this review we also searched the following databases: Sociofile; Cancerlit; IAC Health & Wellness; JICST; Pascal;ERIC; ASSIA; Linguistics and Language Behavior Abstracts; Mental Health Abstracts; CAB Health; DHSS-Data; MANTIS.

Selection criteria

Randomised and quasi-randomised controlled trials that evaluate the effects of providing recordings (for example, audiotapes) or summaries (for example, a letter with reminders of key points) of consultations to people with cancer or their families.

Data collection and analysis

Two authors assessed studies for inclusion. Data were extracted by one author and checked by another author. We assessed study quality on seven criteria. We used a systematic approach to data extraction to produce a descriptive summary of studies, and present a narrative synthesis of the results.
Main results

We included sixteen controlled trials involving 2318 adult participants. The studies measured diverse outcomes. Many of the participants found recordings or summaries of their consultations valuable, with between 60% and 100% of participants (across twelve studies) reading the summary or listening to the recording at least once. The recordings were used to help inform family and friends (range 41.5% to 94.4% of participants in nine studies). Five out of nine studies reported better recall of information for those receiving recordings or summaries. Three out of ten studies found that participants provided with a recording or summary were more satisfied. No studies (out of ten) found any statistically significant difference between groups in terms of anxiety or depression. Three studies evaluated the effects on quality of life, but found no main effects. No study evaluated the intervention’s effects on survival.

Authors’ conclusions

The provision of recordings or summaries of key consultations may benefit most adults with cancer. Although more research is needed to improve our understanding of these interventions, most patients find them very useful. Practitioners should consider offering people recordings or written summaries of their consultations.

Plain language summary

Audio recordings or written summaries of key consultations for adults with cancer

Many people find it hard to remember medical consultations. Providing a record of the conversation may help. The review of trials examined the effects of giving people with cancer audio recordings or written summaries of consultations. Most people found them useful as a personal reminder, to inform their families or friends, or to play to their general practitioners. People tended to remember more of the information they were given, and some were more satisfied with the information they received. Recordings or summaries did not make people more anxious or depressed. The recordings had no effects on quality of life, and no studies measured survival.

Background

Many cancer patients and their families need and want more information than they usually receive in the course of their care (Meredith 1996; NCA 1996). Patients need different types of information at different times and for different purposes, but often feel unable to access information when they need it (Edwards 1997). Information needs differ between individuals and over time.

Potential barriers to meeting patients’ information needs include: limited access to cancer practitioners, a failure by some practitioners to listen and respond to individual patients’ concerns, learning difficulties, and cultural or language differences. There are potential problems with all types of consultations in the amount and type of information given by the doctor. Patients do not always understand the (often technical) language used by doctors, and are not always involved in decision making at the level they would like (Silverman 2005). Also, people often find it difficult to understand and remember information that they are given during consultations, especially if they are distressed (Hogbin 1989; Eden 1994; Northhouse 1987; Rosenbaum 1986). This is especially true for those not familiar with the healthcare system or those who do not speak the same language as the healthcare providers (Kings Fund 2006). People with learning difficulties are often overlooked by healthcare professionals, who expect the carer to make even the most basic decisions on the person’s behalf. The ability of people with learning difficulties to understand and make decisions about healthcare is limited because often they are given very little basic information about health issues (Keywood 1999).

One approach to improving the effectiveness of cancer consultations has been to give patients a recording or summary of the conversation to take home and review in their own time (Butt 1977). People might use recordings or summaries to remind themselves of what was said (McClement 1999), to hear information missed during the consultation (Hogbin 1989) or to help them discuss the consultation with their family or friends (Bruera 1999). Recordings or summaries of consultations might help people to identify questions to ask during subsequent consultations (Ford 1995), or to seek any further information they may require.

Although the provision of recordings or summaries of consultations by practitioners may be relatively cheap and intuitively appealing, its effects in practice need to be evaluated. The aims of
this review were to assess the effects of these interventions and to identify any sub-groups of people who might be more or less likely to benefit from them.

Other approaches to meeting the information needs of patients have been evaluated in Cochrane systematic reviews. For instance, Kinnersley 2007 examines interventions before the consultation for helping people address their information needs, and Johnson et al assessed written and verbal information for patients discharged from acute hospital settings to home (Johnson 2003).

**OBJECTIVES**

To examine the effects of providing recordings or summaries of consultations to people with cancer and their families, on physical and psychological outcomes, information recall and understanding, participation in subsequent consultations, satisfaction, use and opinions, complaints and litigation, and to identify any differential effects on sub-groups.

**METHODS**

Criteria for considering studies for this review

**Types of studies**
Randomised and quasi-randomised controlled trials which evaluate the effects of providing recordings (for example, audiotapes) or summaries (for example, a letter with reminders of key points discussed) of consultations to people with cancer or their families.

**Types of participants**
Participants include adults or children diagnosed with cancer and their close families, including: partners of people diagnosed with cancer; children whose parents have cancer; parents whose children have cancer; and siblings of children with cancer.

**Types of interventions**
Types of intervention include offering or giving cancer patients video recordings, audio recordings or written summaries of their consultations with practitioners.

**Types of outcome measures**
The effects assessed include:
1. Information access, use and understanding (information obtained, recalled and level of understanding, etc);
2. Experience of health care (satisfaction; participation in subsequent consultations; complaints and litigation, etc);
3. Health and wellbeing (physical and psychosocial health status etc).

Data on participants’ uses of recordings and summaries, and their perceptions of their usefulness, were also extracted.

**Search methods for identification of studies**

For the original publication of this review (Scott 1999) the following databases were searched:
- MEDLINE, 1963 to May 1998, ARC service
- The Cochrane Library, 1999 issue 1, CD-ROM
- CINAHL, 1982 to 1998/3, ARC service
- PsycLIT, 1967 to 1998, ARC service
- Sociofile, 1974 to 1998/4, ARC service
- Cancerlit, 1975 to 1998/5, Dialog Corporation Dialog service
- Dissertation Abstracts, 1861 to 1998/5, Dialog Corporation Dialog service
- EMBASE, 1985 to 1998/5 wk 4, Dialog Corporation Dialog service
- IAC Health and Wellness, 1976 to 1998/5 wk 4, Dialog Corporation Dialog service
- JICST, 1985 to 1998/3 wk 4, Dialog Corporation Dialog service
- Pascal, 1973 to 1998/4, Dialog Corporation Dialog service
- PsycINFO, 1967 to 1998/5, Dialog Corporation Dialog service
- ERIC, 1966 to 1998/3, Dialog Corporation Dialog service
- Linguistics and Language Behavior Abstracts, 1973 to 1998/Q2, Dialog Corporation Dialog service
- Mental Health Abstracts, 1969 to 1998/June, Dialog Corporation Dialog service
- AMED, 1985 to May 1998, Dialog Corporation Datastar service
- CAB Health, 1973 to 1998/4, Dialog Corporation Datastar service
- DHSS-Data, 1983 to May 1998, Dialog Corporation Datastar service
- MANTIS, 1987 to May 1998, Dialog Corporation Datastar service
- ASSIA, 1987 to May 1998, Dialog Corporation Datastar service
- Sociological Abstracts, 1998 to 2003 week 2, CSAs Internet Database Service

Search strategies for the original (1999) search are available from the Review Group Editorial Base. An updated search was conducted in January 2003 for the first update of the review (Scott 2003). The following databases were searched:
A further updated search was conducted in March and April 2005, and updated again in May 2007. We searched:

- MEDLINE (Ovid), 1996 to January week 1 2003
- The Cochrane Library, 2002 issue 4
- CINAHL, 1998 to December week 4 2002
- Dissertation Abstracts, 1997 to 2003 (week 2)
- EMBASE, 1996 to 2003 week 2
- PsychINFO, 1998 to January week 2 2003
- AMED, 1985 to December 2002
- Sociological Abstracts, 1998 to 2003 (week 2)

The search strategies used were tailored to each database. The strategy applied to MEDLINE for the latest update of the review (2005, 2007) is presented as an example at Appendix 1. The full search strategies are available from the Review Group Editorial Base.

Data collection and analysis

Two review authors independently assessed the relevance of titles and abstracts retrieved from the database searches. We also checked the bibliographies of identified studies and contacted experts in the field. Two authors independently assessed the full reports of possibly relevant studies for inclusion. Any disagreements were resolved by discussion between the authors. We contacted study authors for clarification where necessary. We included multiple papers from studies if they provided additional data and interpretation.

We used a systematic approach to data extraction to produce a descriptive summary of studies. We present a narrative synthesis of the study findings. We extracted data on the nature and content of the consultations, the type of medium used, the way in which the recording or summary was offered or delivered, and the interventions used in the comparison groups. Outcome data were grouped broadly into three effect types: information recall or understanding; experience of health care (including participation in subsequent consultations, complaints etc.), and health and wellbeing. Data about participants’ uses and opinions of their recordings and summaries were also extracted.

We assessed the following aspects of methodological quality for all included studies:

- methods of recruitment of participants and proportion of participants followed up;
- patients’ awareness of the study;
- method of allocation to groups;
- concealment of allocation
- blinding of clinician(s) and of outcome assessor(s);
- method of analysis (whether or not intention to treat analyses were used);
- numbers of patients and consultants involved in the studies.

This approach allowed the assessment of potential systematic errors, caused by selection bias, response bias, attrition bias and observer bias, the appropriateness of data analysis and the extent to which the study is representative of all people with cancer (Jadad 1998).

We used the Consumers and Communication Review Group’s editorial guidelines on statistical methods where appropriate. However, the studies were too heterogeneous to allow meaningful meta-analyses.

For the original review (Scott 1999), a review advisory panel was established to ensure the scientific validity and relevance of the review. Members of the panel commented on both the protocol and the draft review.

Consumer participation

To ensure that patient views and perspectives were represented in the original review (Scott 1999), the advisory panel included consumers of cancer care and members of consumer advocacy organisations in the United Kingdom, including Cancer BACUP, the National Cancer Alliance, the Consumers’ Advisory Group for Clinical Trials (CAG-CT), and the Standing Advisory Group on Consumer Involvement in the NHS R&D Programme.

An anonymous consumer referee was included by the Consumers and Communication Review Group in the editorial process of the protocol for this review. Consumers’ comments on the draft review were gathered in a workshop discussion of the draft at the 2nd World Conference on Breast Cancer Advocacy in March 1999.

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RESULTS

Recordings or summaries of consultations for people with cancer (Review)
Description of studies

See: Characteristics of included studies; Characteristics of excluded studies.

Results of the search

Thirty-seven potentially relevant studies were considered in detail.

Included studies

We included 16 studies involving 2318 participants: 15 randomised controlled trials (RCTs) and 1 quasi-randomised (sequential) controlled trial, reported in 24 papers. Four of these studies (Hack 2003; Hack 2007a; Hack 2007b; Stephens 2007) were identified in the most recent searches conducted in 2005 and 2007. We obtained additional data from the authors of Stephens 2007. Fifteen included studies compared the effects of audiotapes or written summaries of consultations with another communication aid or usual care. One study compared written summaries with usual care (Damian 1991). One study compared written summaries as a part of a more complex five-step programme with an intervention comprising only a visit-preparation session before the consultation (Sepucha 2000). Two studies compared consultation tapes as part of a more complex information package with usual care (Davison 1997; Reynolds 1981). One study compared consultation tapes with general information tapes (Dunn 1993). Eight studies compared consultation audiotapes with usual care (Ford 1995; Hack 1999; Hack 2003; Hack 2007a; Hogbin 1992; North 1992; Ong 2000; Stephens 2007). One compared audiotapes with summary letters (Tattersall 1994), and one compared audiotapes in addition to written recommendations with written recommendations only (Bruera 1999). One study compared two audiotape formats for the delivery of information relevant to informed consent to participate in a clinical trial (Hack 2007b).

Seven studies recruited people of both sexes and with various types of cancer attending their first consultation with an oncologist (Dunn 1993; Hack 1999; Hack 2003; Hack 2007a; Ong 2000; Reynolds 1981; Tattersall 1994). One study recruited newly referred patients with various advanced cancers to a medical oncology outpatient clinic (North 1992). Two studies recruited men with prostate cancer (Davison 1997; Hack 2007a). Three studies recruited male and female patients attending ‘bad news’ consultations. One of these (Ford 1995) addressed two different sub-populations of people with various types of cancer, including newly diagnosed patients receiving their diagnosis of cancer (‘primary bad news’), and patients with an established diagnosis receiving news that their treatment had thus far been unsuccessful (‘secondary bad news’). A second study recruited male and female patients newly diagnosed with oesophageal or gastric cancer (Stephens 2007). The other ‘bad news’ study recruited a sample of women with early breast cancer referred to a consultant surgeon (Hogbin 1992). One study recruited men and women with various cancers attending a follow-up consultation with a medical oncologist (Damian 1991). One study recruited people of both sexes with advanced cancer attending a multidisciplinary pain and symptom clinic. Most of the patients in this study were not being diagnosed and were therefore not receiving ‘bad news’ (Bruera 1999). One study recruited breast cancer patients consulting one of two physicians (a surgeon or a medical oncologist) (Sepucha 2000). One study recruited females with newly diagnosed breast cancer considering participating in a clinical trial (Hack 2007b). All the studies addressed adults with cancer, although the ages of participants in Ong 2000 ranged from 15 years and in Dunn 1993 from 16 years. Upper age limits ranged from 71 to 93 years. The geographical settings of the included studies varied: six were undertaken in Canada, four in Australia, four in the UK, one in the Netherlands, and one in the USA.

Considerable heterogeneity is evident between the studies in the types of interventions and methods of delivery; in patient populations and cancer sites; in timing of initial intervention and follow-up; and in measured outcomes and statistical techniques. The complex design of three interventions (Davison 1997; Reynolds 1981; Sepucha 2000) make it impossible to attribute changes in outcomes to specific components, only to the intervention as a whole.

Excluded studies

Twenty-one of the studies identified as potentially relevant and considered in full text did not meet the review’s inclusion criteria, either because they did not address people with cancer specifically, or they were not controlled studies. These are listed in the table Characteristics of excluded studies with a reason for exclusion given.

Risk of bias in included studies

We assessed the following aspects of methodological quality for all included studies:

- methods of recruitment of participants and proportion of participants followed up;
- patients’ awareness of the study;
- method of randomisation to groups;
- concealment of allocation;
- blinding of clinician(s) and of outcome assessor(s);
- method of analysis (whether or not intention-to-treat analyses were used);
- numbers of patients and consultants involved in the studies.

Recruitment

Eleven studies reported obtaining informed consent from participants (Bruera 1999; Davison 1997; Hack 1999; Hack 2003; Hack 2007a; Hack 2007b; Hogbin 1992; Ford 1995; Ong 2000; Sepucha 2000; Stephens 2007). It is therefore not clear to what extent people in the remaining five studies were aware that they were involved in a study. However, all participants must have been aware of the interventions that they received.

Method of randomisation

Fifteen of the 16 included studies were described as RCTs; however the method of randomisation was specified in only six studies (Bruera 1999; Damian 1991; Davison 1997; Dunn 1993; Ford 1995; Hack 2007a). Sepucha 2000 was a quasi-randomised (sequential) controlled trial.

Concealment of allocation

Of the fifteen RCTs, concealment of the random allocation sequence until the moment of participant assignment to groups was only clearly done in three studies (Bruera 1999; Ford 1995; Hack 2007a). In the remaining RCTs, concealment of the allocation sequence was unclear. A rating of allocation concealment for each study is given in the table Characteristics of included studies.

Blinding of clinician(s) and outcome assessor(s)

The nature of these interventions and methods of assessment make it especially difficult to blind participants, consultants and assessors to the allocation of trial participants to different intervention or control groups over the whole duration of a study. In eight studies it was clear that the consultant was blinded to the participants’ group allocation at least until the end of the consultation (Bruera 1999; Dunn 1993; Hack 2003; Hack 2007b; Hogbin 1992; Ford 1995; Ong 2000; Tattersall 1994). Three study reports addressed the issue of blinding of assessors (Bruera 1999; Hack 2003; Hack 2007a). In Bruera 1999 the assessor was blinded, except for the final segment in which the members of the intervention group were asked about the cassette. In Hack 2003 and Hack 2007a, treatment groups were only revealed after the post-consultation measures, so initial assessment was blinded. In most of the other studies participants in the intervention groups were questioned about their use and opinions of letters or tapes, so it appears unlikely that assessors were blind to participants’ group allocation.

Methods of analysis

Only four of the studies explicitly adopted an intention-to-treat approach to statistical analysis (Dunn 1993; Ford 1995; Ong 2000; Stephens 2007).

Number of patients and consultants/practitioners involved in the studies

Twelve included studies were single-centre trials; the four other studies took place across various cancer centres in Canada (Hack 1999; Hack 2003; Hack 2007a; Hack 2007b). The total number of participants was 2318, and ranged per study from 24 to 670. The participants in all studies were adults with a diagnosis of cancer. They varied, however, in terms of the type of cancer, the length of time since diagnoses and whether they received ‘good news’ or ‘bad news’ during their consultations.

All the included studies involved specialist practitioners as the consultants. Five studies involved only one consultant (Damian 1991; Dunn 1993; Hogbin 1992; Tattersall 1994; Stephens 2007), and the same consultant was involved in three of these studies. Five studies involved two consultants (Bruera 1999; Davison 1997; North 1992; Reynolds 1981; Sepucha 2000). One involved a team of 5 consultants (Ford 1995), in 4 other studies 11 (Ong 2000), 15 (Hack 2007a), 21 (Hack 2007b) and 40 (Hack 2003) oncologists taped the consultations. The other study did not state how many physicians were involved, but there were at least three, because the study was conducted in three different cities (Hack 1999).

Effects of interventions

Fifteen randomised controlled trials and 1 quasi-randomised (sequential) controlled trial have been published in 24 articles which evaluate the provision of recordings or summaries of consultations to people with cancer. They have compared a variety of interventions among different populations and have measured different types of effect. In all but two of the studies (Ford 1995; Hack 2007b), participants in the intervention groups were given a tape and/or written summary of a single consultation. The purpose and timing of the recorded consultations varied. Three studies recorded diagnostic, or primary ‘bad news’ consultations (Hogbin 1992; Ford 1995; Stephens 2007). Ford 1995 also included secondary ‘bad news’ consultations with patients whose treatment had so far been unsuccessful. Nine studies recorded initial treatment consultations with patients who had been previously told their diagnosis (Davison 1997; Dunn 1993; Hack 1999; Hack 2003; Hack 2007a; North 1992; Ong 2000; Reynolds 1981; Tattersall 1994). In one study the consultations were conducted by physicians to summarise a series of consultations with different members of a multidisciplinary team. In the summary consultation, the physicians provided information and answered questions about the patient’s status and prognosis, and made recommendations about future management.
(Bruera 1999). One study provided cancer patients who were attending a follow up consultation with a written summary of their consultations (Damian 1991). In another study, early-stage breast cancer outpatients making local or systemic treatment decisions and consulting with a surgeon or a medical oncologist about treatment were provided with a written record of their consultation (Sepucha 2000). One study recorded the delivery of information relating to informed consent to participate in a clinical trial in breast oncology given in the initial clinical trial consultation and subsequent meetings with the research nurse (Hack 2007b).

We present a summary of results in the Data and analyses section.

Information recall and understanding

Of nine studies that assessed recall of information given during the consultation (Damian 1991; Dunn 1993; Ford 1995; Hack 1999; Hack 2007b; North 1992; Ong 2000; Reynolds 1981; Stephens 2007), five reported better recall of information among the groups that received recordings or summaries than among control groups (Ford 1995; Hack 1999; North 1992; Ong 2000; Stephens 2007). In the Hack 1999 study patients with prostate cancer who received the audiotape by choice recalled the consultation to have been more thorough than did patients who received the audiotape without choice and those patients who did not receive the audiotape.

Two studies reported on the perceptions of being informed for groups either receiving an audiotape, given a choice or not receiving a tape (Hack 2003; Hack 2007a). Patients who received their tape (whether by choice or not) reported having been provided with significantly more information about the side effects of treatments (Hack 2003) but had no difference in their perception of having been informed. Patients who received an audiotape in the Hack 2007a study reported having been provided with significantly more information about treatment side effects and treatment alternatives, and felt they had been provided with more information overall compared with patients who did not receive an audiotape.

In one study (Bruera 1999) patients who received the audiocassette in addition to the customary written recommendations scored the test on information significantly better than those who did not receive the cassette, but regarding the understanding and recall of the consultation there were no significant differences in the global rating. Participants in a cross-over trial of tapes and written summaries felt that tapes were significantly more effective than letters to remind them of what the consultant had said. However no corresponding difference in actual information recall was found (Tattersall 1994).

In one study, participants in the control group recalled a greater mean percentage of presented facts than those in the intervention groups (Reynolds 1981). One study found no significant difference between groups in the understanding of information (Hogbin 1992).

Experiences of health care

The data on satisfaction was very heterogeneous so it is difficult to be sure that the studies were measuring similar things - variously reported as satisfaction with information received, with the consultation, with interpersonal aspects of medical care, with medical care in general, with patient-physician communication.

Ten studies assessed people’s satisfaction (Bruera 1999; Damian 1991; Dunn 1993; Hack 1999; Hack 2003; Hack 2007a; Ong 2000; Sepucha 2000; Reynolds 1981; Tattersall 1994). In three of these studies, participants with a recording or summary of the consultation were more satisfied than the control group (Damian 1991; Dunn 1993; Ong 2000). One study showed that patients in the intervention group were more satisfied with their consultations than patients in the control group (Ong 2000). One found that participants who received a written summary were more satisfied with the amount of information received than were those in the control group (Damian 1991). Another study found that participants who received a tape of their consultation were more satisfied with their tape than were those who received a general cancer information tape. They were also more satisfied with the consultation than were those who received the general information tape or no tape (Dunn 1993). In a further study (Sepucha 2000), there was a trend for higher satisfaction with a written summary compared to control. Two studies (Tattersall 1994; Bruera 1999) reported that a tape was a more effective reminder than written information. In one study (Hack 1999), overall, patients expressed strong support for receiving the audiotape. All patients offered a choice regarding whether they wanted the audiotape decided to receive the tape.

One study found that participants who had received an audiotape of one consultation were more likely to ask questions for clarification in the subsequent consultation than people in the control group (Ford 1995). The same study found that, during their second consultation, more participants in the control group requested information already supplied to them in their first consultation than did participants in the intervention group. In Hack 1999, across the whole sample there was a correlation at follow up between recall about the extent to which treatment-related concerns were discussed during the consultation, and the degree of satisfaction with the consultation. Patients who recalled extensive discussion were more satisfied. Another study found patients’ decisional control to be significantly associated with satisfaction with communication with the oncologist. Patients adopting a collaborative role were more satisfied than those adopting a passive role (Hack 2007a).

None of the studies reported any complaints or litigation relating to the intervention(s) or the health practitioner’s behaviour during the consultation.

Health and wellbeing
Ten studies assessed anxiety and/or depression (Davison 1997; Dunn 1993; Ford 1995; Hack 1999; Hack 2003; Hack 2007a; Hogbin 1992; North 1992; Stephens 2007; Tattersall 1994). None of them found any statistically significant differential effect between the groups that received and did not receive recordings or summaries of their consultations. Three studies measured the effect of the intervention on patient quality of life and found no main effects (Hack 2003; Hack 2007a; Ong 2000). None of the included studies assessed survival.

Uses and opinions of the interventions

It was consistently reported that most of the patients who received recordings or summaries of their consultations used and valued them. Between 14.3% and 94% of patients in five studies receiving tapes said they had used them as a reminder of what was said during the consultation (Davison 1997; Ford 1995; Hogbin 1992; North 1992; Ong 2000). Between 41.5% and 94.4% of patients in nine studies used the tape to help inform family and friends (Davison 1997; Ford 1995; Hack 2003; Hack 2007a; Hogbin 1992; North 1992; Ong 2000; Stephens 2007; Tattersall 1994). A small proportion (1.3% to 9.6%) from three studies reported playing their tape to their general practitioners or consultants (Hogbin 1992; Ong 2000; Stephens 2007).

Listening to the tape was upsetting for between 3.2% and 17.1% of patients from four studies (Hogbin 1992; Ford 1995; Ong 2000; Stephens 2007). Conversely, 11.1% of patients in one study (North 1992), and 53% of patients in another study (Ong 2000) found the tapes reassuring. Across the twelve studies that provided data on frequency of use (Bruera 1999; Damian 1991; Davison 1997; Hack 1999; Hack 2003; Hack 2007a; Hack 2007b; Hogbin 1992; Ford 1995; North 1992; Ong 2000; Tattersall 1994) between 60% and 100% of participants who received letters or tapes read or listened to them at least once. Average usage (range) varied from 1.3 (range not stated) to 4.09 (range 1 to 10) times in seven studies (Bruera 1999; Davison 1997; Hack 1999; Hack 2007a; Hack 2007b; Hogbin 1992; North 1992). Tattersall 1994 found that recipients of ‘bad news’ and patients with poor prognoses read their letter significantly less often than did recipients of ‘good news’ and patients with good prognoses, but only if they received the letter first. In this study, the emotional impact of the consultation and prognosis did not affect tape usage or letter usage if the letter was received after the tape.

Although a high proportion of responses were in favour of the interventions, the findings about uses and opinions came only from the intervention groups in the trials. They are therefore no stronger than data from uncontrolled studies.

Impact of recording process

Hack 2003 examined the impact of the recording process by comparing the standard care control group with the group that were audiotaped but received no tape, and found no difference in any of the outcomes. Any benefits from the intervention therefore appear to be attributable to some process beyond having one’s consultation audiotaped.

Sub-group analyses

Three studies categorised the information given to participants during the consultation as either ‘good news’ or ‘bad news’. Their findings were mixed. One study found that people who received ‘bad news’ found a summary letter significantly more useful than people who received ‘good news’ (Damian 1991). Another study reported that people who were more anxious and considered they had received ‘bad news’ were less likely to appreciate receiving a reminder of the consultation (Tattersall 1994). One study found that, among people who were given consultation tapes, those with poor prognoses had statistically significant increases in their psychiatric morbidity scores at follow-up compared to people with better prognoses (Ford 1995).

Discussion

As with many communication interventions, providing recordings or summaries of consultations to people with cancer might have an impact on a variety of processes and outcomes that can be measured and valued in different ways (Entwistle 1998). This impact is likely to vary according to the purpose, timing and frequency of consultation recordings given to patients.

There have been no randomised controlled assessments of the effects of the provision of recordings or summaries of consultations on the survival or physical health status of people with cancer. Most of the studies that have evaluated these interventions have investigated the effects on psychological outcomes. This may reflect the fact that doctors have traditionally assumed that information about health problems and treatments makes people anxious and that anxiety is a bad thing (Reiser 1980). The studies reviewed here appear to provide reassurance that recordings and summaries of consultations do not promote anxiety except, perhaps, among people with poor prognoses. The results of the included studies also indicate that people may have mixed reactions to recordings: while some may find a measure of reassurance from tapes, others appear to find listening to recordings of consultations upsetting. The effects of the recordings cannot be distinguished from the effects of the consultation itself; however this remains a potential harm of the use of recordings that should be explored in future research.

There is some evidence to tentatively suggest that the provision of consultation recordings or summaries might enhance patients’ participation in subsequent consultations and in decisions about their care. It is also plausible that there may be a Hawthorne-type
effect associated with the recording of consultations. That is, there might be a positive impact on the content of consultations if practitioners are aware that they are being recorded. However, patients’ consultation behaviours might also be affected. In at least nine of the eleven studies where informed consent was obtained, participants in the control groups would become aware that they had not received a recording or summary. This might have affected their responses to the research instruments. These possibilities need further evaluation.

We identified no reports of cancer patients taking the initiative and making their own recordings of consultations with practitioners. It would be interesting to survey practitioners and patients to discover the extent to which this happens and to study practitioners’ and patients’ behaviour when it occurs. It would also be useful to discover whether practitioners have refused their consent to patients who wish to record their consultations.

The studies reviewed suggest that most people with cancer seem to positively value being given a record of their consultation. In this, they are consistent with evidence from uncontrolled studies (Ah-Fat 1998; Knox 2002; McClement 1999; Ong 1995).

We need to consider the generalisability of the findings of the studies reviewed. Most studies were heterogeneous and three had less than forty participants (Hack 1999; North 1992; Sepucha 2000). Also, the effectiveness of recordings or summaries of consultations may depend in part on the content of the consultation and the way it was conducted. Future research might usefully investigate the relationship between the content and form of the consultation and the effects of providing a record of it. Given that there are differences in the way that health care is financed between some of these countries, it is possible for example that the implications of findings from studies conducted in the USA, where services must be paid for privately or by insurance, will differ from the implications of findings of studies where services are free at the point of use. Furthermore, there may be differences in the way that health care is delivered across these different geographical locations, as well as differences in cultural practices and beliefs. Given such possible differences between healthcare systems, the findings from studies conducted in one setting may not therefore be generalisable across all settings. None of the included studies was conducted in low income countries. However, given that the provision of recordings or summaries of consultations is a relatively low cost and simple intervention, concerns about problems with generalisability may be reduced.

We could not compare of the relative effects of audio recordings and written summaries. The only study (a cross-over trial) to evaluate the relative impact of tapes and summaries found that participants were significantly more satisfied with the tape than with the letter as a reminder of what the consultant had said (Tattersall 1994). However, the same study found that the order in which the interventions were given had no differential effect on information recall between the groups. Further research is required to compare the relative benefits of giving recordings, summaries and other interventions to cancer patients.

Although some of the primary studies state that tape players were available for participants to borrow if required, none report whether participants actually experienced any difficulties in replaying their tapes. Potential difficulties include variations in recording quality, lack of ownership or access to a tape player, and hearing disability. Advances in digital recording may also have an effect on the choice of recording media and access to suitable equipment by patients. One study (Ong 2000) reported that in a few cases (n = 15) patients were excluded from the study because their consultation recording had failed or was incomplete. It is not reported whether any participants who received written summaries had any difficulties reading them due to factors such as language differences, or learning or reading difficulties. The extent to which communication-based interventions such as these raise issues about technical and physical support as well as psychosocial support should be more explicitly recognised.

All but one study recorded one consultation only. Follow-up assessments were completed within eight weeks following the intervention in all studies except for one. These information-giving interventions are very context-specific and arguably remain relevant for a relatively short period of time. At the next consultation, it is likely that different information will be provided and different issues discussed. Further research is needed to study the effects of providing recordings or summaries of a series of consultations. Clinicians who provide recordings or summaries of consultations might need to advise people about how long the information is likely to remain current. There may also be a ‘novelty effect’ to this intervention in that if people are provided with recordings of each consultation, they might listen to them less.

There is tentative evidence to suggest that the interventions may have different effects on different groups of people. They may, for example, be less beneficial to people with poor prognoses. More research is needed to determine which sub-groups are more or less likely to benefit from this type of intervention in terms of differences in cancer site, severity of disease and prognosis, education, learning ability, language and cultural differences. Meanwhile, decisions about who should be given the interventions should take into account people’s medical condition (especially their prognosis), whether they can understand the information, the support they have available, and their expressed preferences for a record of what has been said. If ‘bad news’ has been delivered, other interventions such as follow-up counselling may be needed in addition to recordings or summaries.

The costs of the interventions also need to be considered. None of the reviewed studies contained economic evaluations, but North 1992 reported that the audiotaping of consultations was both cheap and easy and Sepucha 2000 reported that the intervention...
did not significantly increase the time in consultations or significantly affect the number of follow-up consultations before treatment. Nonetheless, the widespread use of audio recordings or written summaries would require resources which would not then be available for other healthcare interventions. The evidence of effectiveness of these interventions is presented by a few small trials with short follow-up periods. It would be prudent to invest resources in larger trials of recordings or summaries that measure outcomes over longer periods, since it is possible that the short-term benefits of these interventions could be outweighed by long-term harms, and vice versa.

Finally, none of the studies reported any problems with complaints or litigation arising from the use of the interventions, although most studies had only short follow-up periods. Two surveys carried out in Australia have suggested that neither doctors nor their defence organisations were concerned about the legal consequences of giving people with cancer recordings or summaries of their consultations (Tattersall 1994; Stockler 1993). It is not clear what the opinions of doctors and their defence organisations in other countries would be.

**AUTHORS’ CONCLUSIONS**

**Implications for practice**

Sixteen studies satisfied the inclusion criteria. Many of the studies were small and considerable heterogeneity is evident between them. Hence, the evidence reported in this review is not very strong and any conclusions must be tentative.

The use of consultation tapes and written summaries is probably helpful for many patients, but not all. Each cancer patient should be assessed carefully in terms of his or her needs, preferences, access to support, and likely responses. The evidence is not yet clear, however, as to which group of patients will most benefit from receiving summaries/recordings.

The studies found that a high proportion of adults with cancer who were attending oncology clinics found consultation tapes or summary letters valuable to remind them of what the consultant had said and for informing others. There is evidence that consultation tapes may improve patient information recall and satisfaction.

There is no evidence that consultation tapes or written summaries affect levels of anxiety or depression in people with cancer. Hence, concern that these interventions might make patients more anxious or depressed should not prevent practitioners from providing tapes or summaries. Nor should such concerns lead practitioners to discourage patients from making their own recordings. However, practitioners should be wary of using these techniques to reinforce ‘bad news’ when alternative interventions such as counselling may be more appropriate.

It is interesting to note that one of the included studies in this review found that recipients of bad news used the summaries less often than those with good news (Tattersall 1994). This highlights the need for clinicians to be sensitive to the context in which information is being provided, and to negotiate with patients regarding their information needs.

As with any healthcare intervention, the patient’s prior informed consent should be obtained. To this end, the consultation should be viewed as an opportunity to discuss which types of information would best meet the individual patient’s needs. This would help to ensure that the information given is relevant to the individual. Practitioners should be aware that consultation recordings and summary letters may need to be given in the context of a supportive environment, allowing patients and family members to follow-up any additional information needs stimulated by the intervention.

**Implications for research**

Sixteen studies with short follow-up periods met all the inclusion criteria of this review. Although patterns of evidence were found between certain studies, any evidence of effect remains weak and uncertain in the long-term.

Although it is clear that many people with cancer find consultation tapes and letters useful, further research is needed to assess the impact of these interventions on health status. Other outcomes which could usefully be explored include psychosocial adaptation and coping behaviour, and the quality of relationships between patients and their families and healthcare providers. However, it may not be realistic to measure such impacts. For many types of cancer, for example, studies would have to include very large numbers and have very long follow-up periods to hope to measure impacts on health status. If recordings/summaries are useful to people and improve their satisfaction with care and their information recall, perhaps this is sufficient to justify their wide use in cancer care.

In addition to larger, more rigorous trials, more qualitative research would be helpful to explore the ways in which patients use and value these types of intervention, as would research designed to explore differential effects on cancer sub-populations. There is also a lack of evidence about the potential value of recordings and summaries at the later stages of cancer care, such as at the termination of successful treatment, when relapses occur, or when patients are advised that they may have only a short time left to live. Further research may be required to discover how often patients seek to make their own recordings or summaries of consultations, how often they are able to do so, and how they use these recordings. The possible harms of these interventions should also be explored; for example, clinicians may see recordings or summaries as a replacement for spending additional time with people to explain issues or answer questions.
ACKNOWLEDGEMENTS

For the original (1999) review:

Julie Glanville for carrying out searches; Claire Glenton for help with assessing an article written in Norwegian; Jos Kleijnen for help with assessing an article written in Dutch; the review advisory panel for comments and suggestions on the protocol and the review (Jacqueline Droogan, Tim Eden, Chris Eiser, Lesley Fallowfield, Kate Flemming, Julie Glanville, Allan House, Martin Ledwick, Deborah Lister-Sharpe, Mari Lloyd-Williams, Fiona McInnes, Mary Miller, Carolyn Pitceathly, Patricia Sloper, Martin Tattersall, Hazel Thornton).

For the 2003 update:

Judy Stoelwinder for assistance with the search strategy; the editors of the Cochrane Consumers and Communication Review Group.

For the 2007-08 update:

Megan Prictor and Simon Lewin for assistance and comments.

REFERENCES

References to studies included in this review

Bruera 1999 (published data only)

Damian 1991 (published data only)

Davison 1997 (published data only)

Dunn 1993 (published data only)

Ford 1995 (published data only)

Hack 1999 (published data only)

Hack 2003 (published data only)

Hack 2007a (published data only)


Hack 2007b (published data only)

Hogbin 1992 (published data only)

North 1992 (published data only)

Ong 2000 (published data only)
Ong LML, Visser MRM, Lammes FB, van der Velden J, Kuenen BC, de Haes JCM. Effect of providing cancer patients with the audiotaped initial consultation on satisfaction, recall, and quality of life: a randomized,

**Reynolds 1981** (published data only)

**Sepucha 2000** (published data only)

**Stephens 2007** (published and unpublished data)

**Stattersall 1994** (published data only)

**References to studies excluded from this review**

**Ah-Fat 1998** (published data only)

**Bell 2003** (published data only)

**Bowden 2003a** (published data only)

**Bowden 2003b** (published data only)

**Butt 1977** (published data only)

**Deutsch 1992** (published data only)

**Eden 1993** (published data only)

**Ellis 1979** (published data only)

**Gent 2003** (published data only)

**Haslop 2005** (published data only)

**Hogbin 1989** (published data only)

**Johnson 1991** (published data only)

**Knox 2002** (published data only)

**Liddell 2004** (published data only)

**Lobb 2002** (published data only)

**Ong 1995** (published data only)
Rosenbaum 1986  {published data only}

Rutherford 1991  {published data only}

Rylance 1992  {published data only}

Sepucha 2003  {published data only}

Tattersall 1990  {published data only}

Additional references

Eden 1994

Edwards 1997

Entwistle 1998

Jadad 1998

Johnson 2003
Johnson A, Sandford J, Tyndall J. Written and verbal information versus verbal information only for patients being discharged from acute hospital settings to home. *Cochrane Database of Systematic Reviews* 2003, Issue 4. [DOI: 10.1002/14651858.CD003716]

Keywood 1999

Kings Fund 2006

Kinnearsley 2007

McClement 1999

Meredith 1996

NCA 1996

Northhouse 1987

Reiser 1980

Silverman 2005

Stockler 1993

References to other published versions of this review

Scott 1999

Scott 2001

Scott 2001a

Scott 2003
Recordings or summaries of consultations for people with cancer (Review)
### Characteristics of included studies  
*ordered by study ID*

**Bruera 1999**

<table>
<thead>
<tr>
<th>Methods</th>
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<tbody>
<tr>
<td><strong>Objective:</strong></td>
<td>to assess the impact on patients' recall of and overall satisfaction with their consultation by the addition of an audiocassette recording of a consultation to written recommendations.</td>
</tr>
<tr>
<td><strong>Study Design:</strong></td>
<td>Double-blind RCT.</td>
</tr>
<tr>
<td><strong>Recruitment:</strong></td>
<td>not stated.</td>
</tr>
<tr>
<td><strong>Randomisation:</strong></td>
<td>randomisation took place according to a computer-generated code. The allocation of each patient to the tape or no-tape group was kept in sealed envelopes. These envelopes were opened by a pharmacist at the end of the consultation after the patient and physician had completed their discussions.</td>
</tr>
<tr>
<td><strong>Clinician blind:</strong></td>
<td>yes.</td>
</tr>
<tr>
<td><strong>Assessor blind:</strong></td>
<td>yes, except for the final segment in which the intervention group were asked about the cassette.</td>
</tr>
<tr>
<td><strong>Patient awareness of study:</strong></td>
<td>written informed consent.</td>
</tr>
<tr>
<td><strong>Total number approached:</strong></td>
<td>72.</td>
</tr>
<tr>
<td><strong>Number agreed to participate:</strong></td>
<td>71.</td>
</tr>
<tr>
<td><strong>Methods of analysis:</strong></td>
<td>two-tailed unpaired Student t test, descriptive statistics (median values, quartiles), univariate correlations.</td>
</tr>
<tr>
<td><strong>Intention-to-treat:</strong></td>
<td>not stated.</td>
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</table>

<table>
<thead>
<tr>
<th>Participants</th>
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<tbody>
<tr>
<td><strong>Country:</strong></td>
<td>Canada.</td>
</tr>
<tr>
<td><strong>Diagnosis:</strong></td>
<td>advanced cancer, defined as locally recurrent and/or metastatic.</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td>mean age was 62 (SD10) years.</td>
</tr>
<tr>
<td><strong>Sex:</strong></td>
<td>male and female.</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td>not stated.</td>
</tr>
<tr>
<td><strong>Exclusions:</strong></td>
<td>no admission to the clinic or no diagnosis of advanced cancer; clinical evidence of language, cognition, or hearing impairment; no follow-up visit expected to take place in 1 week's time; no written, informed consent.</td>
</tr>
<tr>
<td><strong>Clinical setting:</strong></td>
<td>Multidisciplinary Pain and Symptom Clinic, Cross Cancer Institute</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Interventions</th>
<th></th>
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<tbody>
<tr>
<td><strong>Consultation type:</strong></td>
<td>The clinic was designed to provide multidisciplinary assessment and management of symptoms to patients and their families during one or two visits. During half a day patients have consultations with specialists in a number of disciplines. After that, the specialists meet in order to discuss the case. Physicians then return to the room in order to provide patients and their accompanying relatives with recommendations and instructions and answers questions regarding the patients' status and prognosis. This second visit by the two staff physicians was utilized for the assessment of the recording method. When the physician returned to the patient's room, in all cases, two tape recorders were activated. One tape was given to one of the research nurses, who did not know whether the other tape had been delivered to the patient or not. The pharmacist delivered the other tape to the patients if they had been allocated to the tape group. Additionally, at the end of the clinic, the nurses provided the patients with a written summary of recommendations by specialists in all disciplines and detailed written information about medications. I1 (n = 38): audiocassette in addition to written recommendations. I2 (n = 33): no audiocassette in addition to written recommendations. N = (baseline) 71</td>
</tr>
<tr>
<td><strong>Theoretical basis:</strong></td>
<td>not stated.</td>
</tr>
</tbody>
</table>
Bruera 1999  (Continued)

| Outcomes | Timing of outcome assessment: When the patients returned for their second visit during Day 8 Use and opinions of audiotapes: Patient opinion of the level of communication with their own family about their illness during the last week, the intervention group was asked about the utilization and role of the cassette in influencing the level of family communication; Information: recall of information given; Satisfaction: global patient satisfaction with the clinic; global patient satisfaction with their understanding and recall of discussion |
| Notes | Power calculation: not stated. Most of the patients were not being diagnosed and were therefore not receiving 'bad news'. The distribution of dropouts in the two experimental groups was similar in regard to patients who did not return. Relatively small sample size. |

Risk of bias

<table>
<thead>
<tr>
<th>Item</th>
<th>Authors' judgement</th>
<th>Description</th>
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<tr>
<td>Allocation concealment?</td>
<td>Yes</td>
<td>A - Adequate</td>
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</table>

Damian 1991

Methods

Objective: to assess whether letters to patients outlining their cancer consultation influence their satisfaction and recall of information, and whether they are useful to cancer patients and their families. Study design: RCT. Recruitment: not stated. Randomisation: at the end of the consultation, patients were randomised to either receive or not receive a letter outlining their consultation. Assignment to the intervention (letter) or control (no letter) groups was done by the use of pre-randomised forms numbered to correspond to patients' order of entry into the study. Clinician blind: not stated. Assessor blind: not stated. Patient awareness of study: not stated. Total number approached: 48. Number agreed to participate: 48. Method of analysis: Wilcoxon rank sum test, linear regression analysis (SPIDA statistical package), Student's t test. Intention-to-treat: not stated.

Participants

Country: Australia. Diagnosis: patients attending a general oncology outpatient clinic for a follow-up consultation. Age: range 21 to 71 years. Sex: men and women. Ethnicity: not stated. Exclusions: patients attending check-ups only (no discussion of treatment strategies, change in disease status, or intercurrent disorders); non-English speaking; or considered too ill or disabled to be interviewed. Clinical setting: University teaching hospital.
Consultation type: follow-up consultation with medical oncologist. All patients had met the consultant previously: median number of previous consultations 6; range 1-20.
After each clinic, the consultant noted the salient points for all patients.
I (n = 24): consultant dictated individualised letters to those in the letter group.
C (n = 24): no letter dictated or sent.
N = (baseline) 48.
Theoretical basis: not stated.

Timing of outcome assessment: structured telephone interview 3 to 19 days after consultation (median 8 days for the letter group, 7 days for the control group)
Patient recall (prompted and unprompted) of information judged salient by oncologist.
Patient satisfaction with consultation.
Patients in the control group were asked if they thought that a letter outlining their consultation would be useful or distressing to them.
Use and opinions of intervention: patients in the letter group were asked answer a series of open-ended and fixed response questions about the letter they had received.
In addition, 62 of the 71 referring doctors completed a questionnaire about the use of letters to cancer patients (40/45 GPs and 22/26 specialists)

Power calculation: not stated.
Single consultant involved in all consultations.
All patients were asked if they felt the consultation has differed in any way from the previous meetings with the oncologist. 4 thought that it was longer and more informative than usual, and 2 felt that the oncologist had been especially honest with them this time

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<tr>
<td>Allocation concealment?</td>
<td>Unclear</td>
<td>B - Unclear</td>
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</table>
### Methods

**Objective:** to determine whether assisting men with prostate cancer to obtain information would enable them to assume a more active role in treatment decision making and decrease their levels of anxiety and depression.

**Study design:** RCT.

**Recruitment:** Consecutive sample. All men approached agreed to participate. The investigator obtained informed written consent from the patients after explaining the purpose of the study.

**Randomisation:** predetermined by block randomisation to ensure an equal number of intervention and control patients for each physician (34 were recruited from one physician and 26 from the other).

**Clinician blind:** no.

**Assessor blind:** no.

**Patient awareness of study:** purpose of study explained by investigator.

**Total number approached:** 60.

**Number agreed to participate:** 60.

**Method of analysis:** Coombs’ unfolding technique, chi-square test, Student’s t-test.

**Intention-to-treat:** not stated.

### Participants

**Country:** Canada.

**Diagnosis:** newly diagnosed patients with prostate cancer who had been told their diagnosis and had not had their initial treatment consultation.

**Age:** range 41 to 81 years.

**Sex:** men.

**Ethnicity:** not stated.

**Exclusions:** Unable to read, speak, or write English; evidence of mental confusion

### Interventions

**Consultation type:** initial treatment consultation. Prior to the consultation* all patients were interviewed to introduce them to the idea that decisions would have to be made about treatment and that the investigator was interested in assessing the extent to which they would like to participate in making those decisions. Baseline measurements were taken at this stage. All patients were provided with the same written information package consisting of five brochures containing various types of information about prostate cancer.

**I** (n = 30): Men in the intervention group were encouraged to consider what type of information they needed to assist them in deciding which treatment would be best for them. Investigator and patient then examined a list of potential questions to ask the urologist. They also reviewed the information package. Additional questions that arose from the discussion were added to the list, and the final list of questions was given to the participant. Each individual was given a blank audiotape and made responsible for asking the physician to tape their consultation. These men were also encouraged to bring their spouse/significant other(s) to the treatment consultation.

**C** (n = 30): Participants and their significant other(s) were given the information package, showed what it contained and told that it might be helpful to read it before or after the initial treatment consultation with their physician. They were not given either support in its use or a consultation tape.

The follow-up interviews were conducted by telephone. Part Two of the SDQ was completed to evaluate the intervention. The CPS, CES-D, and STAI were sent out to all participants in a self-addressed envelope on the same day as the telephone interview.

**N =** (baseline) 60.

**Theoretical basis:** Empowerment Model.

### Outcomes

**Timing of outcome assessment:** approximately 5 to 6 weeks after the initial interview.

**Psychology:** the Spielberger State-Trait Anxiety Inventory (STAI), and the Centre for Epidemiologic Studies Depression Scale (CES-D).

**Participation:** The Control Preferences Scale (CPS).
Davison 1997  

(Continued)

<table>
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<tr>
<th>Notes</th>
<th>Use and opinions of intervention: Sociodemographic Profile Questionnaire (SDQ) (Part Two)</th>
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<tr>
<td></td>
<td>Power calculation: not stated.</td>
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<tr>
<td></td>
<td>*Exact timing unclear.</td>
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<tr>
<td></td>
<td>The intervention was complex, having four main components (printed materials, question list, support and consultation audiotape). Hence, the significant differences in measured outcomes can only be attributed to the intervention as a whole.</td>
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<tr>
<td></td>
<td>At pre-test, I patients had significantly higher levels of state anxiety than C patients. This suggests that the groups were not comparable at baseline.</td>
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**Risk of bias**

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<tr>
<td>Allocation concealment?</td>
<td>Unclear</td>
<td>B - Unclear</td>
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Dunn 1993

**Methods**

- Objective: to compare the effects of giving patients an audio-tape of their consultation, an audio-tape of general information, or no tape, on patient satisfaction, psychological adjustment and information recall.
- Study design: RCT.
- Recruitment: not stated.
- Randomisation: patients were randomised to 3 groups at the end of the consultation, using random number tables (randomised block design to ensure equal numbers in each group).
- Clinician blind: yes.
- Assessor blind: not stated.
- Patient awareness of study: not stated.
- Total number approached: 170.
- Number agreed to participate: 142.
- Method of analysis: ANOVA with planned contrasts, Student's one-tailed t-test, multiple and linear regression analysis.
- Intention-to-treat: yes.

**Participants**

- Country: Australia.
- Diagnosis: inpatients and outpatients attending their first consultation with a medical oncologist.
- Age: mean age 52 years, range not stated.
- Sex: men and women.
- Ethnicity: not stated.
- Exclusions: younger than 16 years or older than 75 years; non-English-speaking; advanced incapacity; diagnosis other than cancer; unavailability for duration of follow-up.
- Clinical setting: University teaching hospital.

**Interventions**

- Consultation type: first visit with a medical oncologist. All consultations were audio taped. Patients were randomised to receive the consultation tape, a general tape describing cancer, or no tape.
- I1 (n = not stated): patients were given a copy of the consultation audio-tape to take home.
- I2 (n = not stated): patients were given a general tape describing cancer in question-and-answer format narrated by a group of oncologists, including the oncologist participating in this study.
- C (n = not stated): patients were not given either tape.
Dunn 1993  (Continued)

| Outcomes | Timing of outcome assessment: 1 to 3 weeks after the consultation  
Psychological adjustment: patients completed the Psychological Adjustment to Cancer (PAC) scale.  
Information recall: spontaneous recall and prompted recall based on a content analysis from a pilot study.  
Since consultations contained different amounts of information, scores for spontaneous, prompted, and total recall were each converted to a percentage of information presented, based on a content analysis of the individual tape.  
Salient recall was measured by comparison with the most significant points covered in the consultation as documented by the oncologist immediately after each consultation.  
Satisfaction: satisfaction with the amount and quality of the information received in the consultation.  
Patients who received either tape also answered 7 additional items addressing their satisfaction with the tape |
| Notes | Power calculation: sample sizes calculated based upon previous randomised studies. A single oncologist participated in all consultations |

**Risk of bias**

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<td>Allocation concealment?</td>
<td>Unclear</td>
<td>B - Unclear</td>
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</table>

Ford 1995

| Methods | Objective: to examine the effect of providing patients with an audiotape of a previous consultation on their level of participation during a subsequent consultation. to test the effects of giving patients an audiotape recording of a 'bad news' consultation on psychological morbidity, information retention, and attitudes to the tape.  
Study design: RCT.  
Recruitment: consecutive eligible patients.  
Randomisation: immediately after their interviews patients were allocated to a tape (experimental) or no-tape (control) condition using the Cancer Research Campaign Clinical Trials Centre telephone randomisation service.  
Clinician blind: yes.  
Assessor blind: not stated.  
Patient awareness of study: the nature of the study was explained to eligible patients. Written consent was obtained to audiotape the consultation as part of the recruitment process.  
Total number approached: not stated.  
Number agreed to participate: 117.  
Method of analysis: Mann-Whitney U test, t-test, MANOVA repeated measures, Friedman two-way ANOVA, Pearson correlation coefficients, chi-squared test, Wilcoxon rank sum test.  
Intention-to-treat: yes. |
Diagnosis: (1) Newly diagnosed patients receiving ‘primary bad news’ of the diagnosis itself or (2) patients with an established diagnosis in whom initial treatment had so far been unsuccessful (‘secondary bad news’). Diagnostic sites included gestational trophoblastic disease (GTD), testicular, breast, bowel, ovary, |
lung, and other tumours.
Age: Mean 45 (SD 15.8), tape group; 44 (SD 17.7) control group; range 21 to 75 years.
Sex: men and women.
Ethnicity: not stated.
Exclusions: younger than 21 or older than 75; non-English speaking or writing; primary or secondary brain disease.
Clinical setting: University teaching hospital.

| Interventions | Consultation type: primary or secondary bad news consultation. In line with departmental practice, patients had two linked consultations with one of five clinicians (three consultants and two senior registrars) which were both audio-taped.
|              | I (n = 63): patients were given the interview tapes after their consultation and encouraged to listen to them at home. Cassette players were provided if needed.
|              | C (n = 54): the interview tapes were not given to these patients.
| N = (baseline) 117. |  

| Theoretical basis: not stated.

| Outcomes | Timing of outcome assessment: Data were collected in three stages. Immediately prior to the first clinical interview, demographic data were collected and baseline measures of psychological symptoms were made. The same instruments were readministered immediately before the second interview, an average of one month after the first. The tapes of both linked interviews were subjected to content analysis to detect differences in the patient's participation associated with listening to the first tape. At stage 3, a mean of 5 months after baseline, a postal follow-up was conducted.
| Psychological symptoms were measured using the 30-item version of the General Health Questionnaire (GHQ-30), and the 14-item Hospital Anxiety and Depression Scale (HADS).
| Participation: Analysis of the consultation tapes was conducted using the Roter Interaction Analysis System (RIAS). One researcher coded and analysed the original tapes and a random sample of 10% was double-coded by a second trained coder to assess intercoder reliability.
| Information: Information retention questionnaire (measure not specified).
| Use and opinions of intervention: attitude to tape questionnaire - tape group only (measure not specified).

| Notes | Reported in two papers, each with different outcomes.
| Power calculation: not stated.
| Five clinicians participated in the consultations.

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<tr>
<th>Risk of bias</th>
<th>Item</th>
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<th>Description</th>
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<tr>
<td></td>
<td>Allocation concealment?</td>
<td>Yes</td>
<td>A - Adequate</td>
</tr>
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</table>
### Methods

**Objective:** to examine the efficacy of offering patients with breast or prostate cancer in Canada an audiotape of their primary oncology treatment consultations.

**Study design:** RCT (pilot).

**Recruitment:** patients were solicited from cancer centers in three Canadian cities.

**Randomisation:** not stated. At each geographic site, a cap of 4 patients per group was established to ensure equal numbers of patients in each group.

**Clinician blind:** not stated.

**Assessor blind:** no.

**Patient awareness of study:** yes. Each patient met with the research assistant immediately before the primary treatment consultation. After being introduced to the patient by a clinic nurse, the research assistant described the study, addressed all the patient’s questions and concerns, obtained the patient’s informed written consent, and then completed a sociodemographic patient profile.

**Total number approached:** 38.

**Number agreed to participate:** 36.

**Method of analysis:** nonparametric tests, Kruskal-Wallis analysis of variance (ANOVA), chi-squared.

**Intention-to-treat:** not stated.

### Participants

**Country:** Canada.

**Diagnosis:** breast cancer or prostate cancer (mean of 3.0 months between diagnosis and treatment consultation).

**Age:** women’s mean age was 52 (range 34 to 77) years; men’s mean age was 67 (range 51 to 79) years.

**Sex:** male and female.

**Ethnicity:** The ethnicity of 11 patients in both groups was either English or French.

**Exclusions:** having a recurrent disease; younger than 18 years old; not being fluent in English; not having normal hearing; having any dementia or other ailment that would make it impossible for them to understand the study and give fully informed consent.

**Clinical setting:** Cancer centers in three Canadian cities.

### Interventions

**Consultation type:** initial treatment consultation with an oncologist. Given the importance of the information provided by the consultation audiotapes, the research assistant told each patient that the consultation would be audiotaped for later content analysis. Any patient who requested the audiotape but was not in the group that would receive one immediately after the consultation was told that a copy would be made available when the study was completed. During the consultation, the oncologist turned the tape recorder on after taking the patient’s history and completing the physical examination and shut the machine off at the end of the discussion about treatment.

**Group 1 (n = 12):** did not receive an audiotape.

**Group 2 (n = 12):** did receive an audiotape.

**Group 3 (n = 12):** was given the choice of receiving or not receiving an audiotape.

**N =** (baseline) 36.

**Theoretical basis:** for one hypothesis the Cognitive Dissonance Theory (Festinger)

### Outcomes

**Timing of outcome assessment:** Immediately before the primary treatment consultation a sociodemographic patient profile was completed. After the consultation a questionnaire was completed by the patient. Follow-up assessments were conducted by telephone six weeks after the primary treatment consultation. A few days before the follow-up assessments, patients received copies of all questionnaires by mail, excluding the information recall and audiotape questionnaires.

**Psychology:** State Anxiety Inventory.

**Use and opinions of intervention:** Audiotape questionnaire.

**Information:** Information Recall Questionnaire.

**Satisfaction:** Patient Perception Scale, Physicians’ Perceived Likability and Technical Expertise Scale.
Hack 1999  (Continued)

| Participation: Control Preferences Scale. |
| Notes | Power calculation: not stated.  
The size of the sample precluded the application of more robust methods of statistical analysis |

**Risk of bias**

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<td>Allocation concealment?</td>
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Hack 2003

**Methods**
- Objective: to examine the impact of providing newly diagnosed breast cancer patients with an audiotape of their initial adjuvant treatment.
- Study design: Multisite RCT.
- Recruitment: Women with a confirmed diagnosis of breast cancer presenting to one of 6 tertiary or community oncology clinics in 4 Canadian cities for their primary adjuvant treatment consultation. Forty medical and radiation oncologists agreed to have their consultations audiotaped.
- Randomisation: Block randomisation to one of four groups; method not further specified.
- Clinician blind: Aware of whether treatment or control, but blind to treatment group assignment (T1, T2 or T3).
- Assessor blind: Aware of whether treatment or control; blind to treatment group assignment until after post-consultation measures.
- Patient awareness of study: Pre-consultation informed consent. Two consent forms were utilised to ensure that patients in the standard care control group were not aware of the audiotape intervention.
- Total number approached: 785; 115 declined to participate.
- Number agreed to participate: 670; 37 didn't complete, 4 refused tape, 1 given tape in error, 628 included in analysis.
- Method of analysis: Descriptive statistics, correlation matrices, Cronbach's alpha coefficients (for all psychological measures), regression analysis. Linear contrast analysis was used to assess the difference in mean scores for the control and treatment groups for (i) tape (assigned and chosen) versus no tape (assigned and standard care control), (ii) no tape (assigned) versus standard care control, and (iii) tape (assigned) versus tape (chosen).
- Intention-to-treat: No.

**Participants**
- Country: Canada.
- Diagnosis: breast cancer (confirmed diagnosis).
- Age: Over 18 (mean 56.5 years (SD 12.0)).
- Sex: Female.
- Ethnicity: Not stated.
- Exclusions: Cognitive impairment that would prevent informed consent.
- Clinical setting: 6 cancer treatment facilities.

**Interventions**
- Consultation type: primary adjuvant treatment consultation.
  - C (n = 158) standard care control; consultation not audiotaped.
  - T1 (n = 147) audiotaped; not given audiotape.
  - T2 (n = 174) audiotaped; patient given audiotape.
  - T3 (n = 153) audiotaped; patient offered choice of receiving audiotape or not. 4 people declined to receive
the tape and were removed from further analysis.
Theoretical basis: not stated.

### Outcomes

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<thead>
<tr>
<th>Timing of outcome assessment:</th>
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<tbody>
<tr>
<td>pre-consultation - Control Preference Scale</td>
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<tr>
<td>immediately after consultation - Control Preference Scale, Patient Perception Scale</td>
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<tr>
<td>12 weeks post consultation - Control Preference Scale; Patient Perception Scale; Audiotape Use and Satisfaction Questionnaire, Informed Communication Scale, Profile of Mood States and Functional Assessment of Cancer Therapy</td>
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<tr>
<td>Predictive value of patient involvement in treatment decision making; Control preference scale.</td>
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<tr>
<td>Information recall: Informed communication scale.</td>
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<tr>
<td>Satisfaction with communication: Patient Perception Scale.</td>
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<tr>
<td>Use and opinion of intervention: Audiotape Use and Satisfaction Questionnaire.</td>
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<tr>
<td>General emotional disturbance: Profile of Mood States (POMS).</td>
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<tr>
<td>Quality of life: Functional Assessment of Cancer Therapy (FACT-B)</td>
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</table>

### Notes

| Median number of patients accrued per oncologist was 12.5. |  |
| There were no statistically significant differences in the demographic or treatment variables across the control and three treatment groups. |  |
| Efficiency of randomisation tested using analyses of variance. |  |
| Power calculation: not stated. |  |

### Risk of bias

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</table>
### Methods

Objective: To assess the efficacy of providing men with prostate cancer with an audiotape of their primary treatment consultation.

Study design: Multisite RCT.

Recruitment: Men with a confirmed diagnosis of prostate cancer presenting to one of 4 cancer centres in Canada. Fifteen radiation oncologists agreed to have their consultations audiotaped.

Randomisation: Block randomisation to 1 of 4 groups (block size = 24 patients) using random number generating software. The assignments were prepared in 2 sealed envelopes; the first indicated whether the patient was in the control (C) arm or an audiotape treatment (T) group, and the second (tucked within the first envelope) of which listed the patient’s assigned treatment arm (T1, T2, T3).

Clinician blind: Aware of whether control or treatment group, but blind to treatment group assignment (T1, T2 or T3) until after the post-consultation measures were completed.

Assessor blind: Aware of whether control or treatment group but blind to each patient’s treatment group assignment until after the post-consultation measures were completed.

Patient awareness of study: Two consent forms were utilised to ensure that the patients in the standard care control group were not informed about the audiotape intervention.

Total number approached: 485. 19 declined.

Number agreed to participate: 466; 37 did not complete the study; 429 completed the study. 4 of those offered a choice of receiving a tape declined to do so, leaving 425 participants in the analysis.

Method of analysis: Descriptive statistics; Cronbach’s alpha coefficients for psychological measures; linear contrast analyses to assess the difference in mean scores for (i) tape (assigned and chosen) versus no tape (assigned and standard care control), (ii) no tape (assigned) versus standard care control, (iii) tape (assigned) versus tape (chosen); hierarchical regression analysis to examine the predictive relationship between patients’ preferred and assumed roles in treatment decision making and 12-week post-consultation outcome for those patients who listened to the consultation audiotape.

Intention-to-treat: No - analysis conducted on 425 patients; excluded 4 patients who declined to receive the audiotape.

### Participants

Country: Canada.

Diagnosis: Prostate cancer.

Age: Over 18; (mean 67.4 years (SD 7.7)).

Sex: Male.

Ethnicity: Not stated.

Exclusions: Cognitive impairment that would disable patient from providing informed consent.

Clinical setting: Four cancer treatment centres.

### Interventions

Consultation type: Primary treatment consultation.

1. Standard care control group - consultation not audiotaped (C) (n = 113).
2. Audio-taped - patient not given audiotape (T1) (n = 98).
3. Audio-taped - patient given audiotape (T2) (n = 120).
4. Audio-taped - patient offered choice of receiving the audiotape or not (T3) (n = 94 accepted tape; the 4 who declined the audiotape were excluded from the analysis).

Theoretical basis: Not stated.

### Outcomes

Timing of outcome assessment:

- Pre-consultation - Control Preference Scale.
- Immediately after consultation - Control Preference Scale; Patient Perception Scale.
- 12-weeks post-consultation - Control Preference Scale; Patient Perception Scale; Audiotape Use and Satisfaction Questionnaire; Informed Communication Scale; Profile of Mood States (POMS); Functional Assessment of Cancer Therapy (FACT-P)
- Information recall: Informed Communication Scale.
Satisfaction with communication: Patient Perception Scale.
Participation: Control Preference Scale.
Use and opinion of intervention: Audiotape Use and Satisfaction Questionnaire.
General emotional disturbance: Profile of Mood States.
Quality of life: Functional assessment of Cancer Therapy (FACT-P)

Notes
The median number of patients accrued per oncologist was 34.
Power calculation: sample size determined using dependent measures from earlier breast cancer study.
No statistically significant differences in the demographic, illness, or treatment variables across the control, and three treatment groups.
Efficiency of randomisation tested using analyses of variance

Risk of bias

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<td>Allocation concealment?</td>
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Hack 2007b

Methods
Objective: To systematically compare two audiotape formats for the delivery of information relevant to informed consent to participate in a clinical trial in breast oncology, and to establish the feasibility of adding a consultation recording protocol to a clinical treatment trial.
Study design: RCT piggy-backed onto on-going clinical trial.
Recruitment: women eligible for a radiation trial were asked to consent also to participating in audiotape companion study. Twenty-one oncologists participated.
Randomisation: Block randomisation procedure; no further details.
Clinician blind: Yes; all consultations were audiotaped prior to randomisation.
Assessor blind: Not stated.
Patient awareness of study: Approached by clinical trial nurse, consented by audiotape research nurse.
Total number approached: Not stated.
Number agreed to participate: 69.
Method of analysis: Descriptive statistics; one-way chi square test to assess whether there was a significant difference in the number of patients who preferred one audiotape format other the other (standardised versus consultation audiotape); two-tailed alpha value of 0.05 was used to establish significance. Consultation audiotapes were coded for 14 discussion points from the Patient Perception of Being Informed subscale of the Informed Consent Questionnaire.
Intention-to-treat: yes (all randomised participants were analysed)

Participants
Country: Canada, 4 provinces;
Diagnosis: women newly diagnosed with breast cancer, considering participation in a randomised clinical trial comparing breast irradiation alone versus breast irradiation plus regional nodal radiation in women with a moderate risk of regional recurrence after breast conserving surgery.
Age: Not stated.
Sex: Female.
Ethnicity: Caucasian (98.6%); Asian (1.4%).
Exclusions: Not stated.
Clinical setting: 5 regional cancer centres.
Interventions
Consultation type: Initial clinical trial consultations with oncologist, and radiation trial nurse if appropriate. All consultations were audi-taped before randomisation for the audiotape trial. The oncologist turned on the tape machine after the history and physical examination, prior to treatment-related discussion including the clinical trial. Any meeting with the research nurse about informed consent was also included on the consultation audiotape.
Interventions: Consultation audiotaped for all patients
Group 1 - standardized audiotape (n = 22).
Group 2 - consultation audiotape (n = 20).
Group 3 - both audiotapes (n = 27).
No control group.
N = 69.
Theoretical base: Not stated.

Outcomes
Timing of outcome assessment: 7 to 10 days after consultation (patients contacted by radiation nurse one week after consultation, with regard to participation in radiation trial; audiotape research nurse contacted patient within following 3 days)
Perception of being informed about clinical trials: Patient Perception of Being Informed (PPBI) subscale of Informed Consent Questionnaire.
Knowledge of information relevant to providing informed consent to clinical trial: Patient Knowledge of Information Relevant to Informed Consent to Clinical Trials (PKI) subscale of Informed Consent Questionnaire.
Satisfaction with communication with a health professional during the consultation: Patient Perception Scale.
Use and opinions of intervention (including preference for audiotape format): Audiotape Use Questionnaire. Feasibility and interest in audiotape clinical trials also rated by participating oncologists and research nurses/associates

Notes
The median number of patients per oncologist was 3 (range 1 to 11).
Power calculation: Not stated. Small sample size.
No significant differences in demographic, illness and treatment summary information across the groups

Risk of bias
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Methods

Objective: to examine whether audiotapes of 'bad news' consultations improved patients' retention of information given during the interview and whether the provision of tapes has any bearing on psychological morbidity and other post-consultation events.

Study design: RCT.

Recruitment: consecutive referrals.

Randomisation: numbers assigned to patients in batches of 10. Those numbers were then pseudo-randomised so that for every 10 patients seen, 5 would be in the tape group and 5 would be in the no-tape group.

Clinician blind: consultant and the breast nurse counsellor were unaware of who received a tape, unless they were subsequently told by that patient.

Assessor blind: not stated.

Patient awareness of study: the consultant told the patients that he was doing research in the area of communication and to find out how much people understood of what was said and whether they were upset by it.

Total number approached: 87.

Number agreed to participate: 83; 67 completed the study.

Method of analysis: Wilcoxon test, Mann-Whitney U test, chi-squared test.

Intention-to-treat: not stated.

Participants


Diagnosis: women with early breast cancer - defined as tumours of 5 cm or less, with or without palpable axillary nodes and no evidence of metastases.

Age: range 36 to 82 years.

Sex: women.

Ethnicity: not stated.

Exclusions: no exclusion criteria stated.

Clinical setting: not stated.

Interventions

Consultation type: initial consultation with a consultant surgeon. Each initial consultation was taped.

Following the consultation, three questionnaires were administered, following which the patient was either given the tape of the consultation to take home and listen to or not given the tape.

I (n = 33) patients were given the tape and a sheet on which to record how often they listened to the tape, with whom, and any comments they would like to make.

C (n = 34) patients were not given the consultation tape.

The patients were seen a second time by the research assistant two to three days preoperatively when the questionnaires were again administered and the patients were asked if they had sought further information, e.g., from their general practitioner, the breast nurse counsellor, from cancer literature, or elsewhere. A record was also made of any treatment they were receiving and whether the tape group subjects were upset by the tape.

Also at this interview the patients' partners completed the Understanding Questionnaire and the HADS. The patients and partners were seen separately for these interviews. A final interview was completed six weeks postoperatively, when the patients completed both the HADS and RSCL, and the partners completed the HADS.

Theoretical basis: not stated.

N = (baseline) 67.

Outcomes

Timing of outcome assessment: (1) 2 to 3 days preoperatively (approximately two weeks after baseline), (2) 6 weeks postoperatively

Psychology: anxiety and depression - Hospital Anxiety and Depression Scale (HADS); and experience of psychological and physical distress - Rotterdam Symptom Checklist (RSCL).
**Hogbin 1992 (Continued)**

| Information: patient’s understanding of her disease and treatment - Understanding Questionnaire (specifically designed for this study). Use and opinions of intervention: Hogbin and Fallowfield questionnaire |

**Notes**

| Power calculation: not stated. A single consultant was involved in all consultations. |

**Risk of bias**

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**North 1992**


| Interventions | Consultation type: initial consultation for new referrals to a medical oncology outpatient clinic. The consultants used a checklist of information. Independent validation that standard information was given was obtained from an independent witness using the same checklist. I (n = 18) consultations were audio taped and patients were given the tape to take home. C (n = 16) consultations were not taped. N = (baseline) 34. Theoretical basis: not stated. |

Notes
- Power calculation: not stated.
- Two consultant oncologists were involved in the consultations.
- The small sample size limits the generalisability of the results.

### Risk of bias

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### Ong 2000

**Methods**
- Objective: to assess the effectiveness of providing cancer patients with the audiotaped initial consultation.
- Study design: double-blind RCT.
- Recruitment: consecutive referrals.
- Randomisation: While the consultation took place, stratified randomisation per clinician took place.
- Method not stated.
- Clinician blind: yes.
- Assessor blind: not stated.
- Patient awareness of study: patients were sent the informed consent form together with the baseline questionnaire a few days before the initial consultation.
- Total number approached: 284.
- Number agreed to participate: 216.
- Method of analysis: Student’s t test (two-sided), chi-squared test (two-sided), descriptive statistics (frequencies), repeated measures analysis of variance, analysis of variance.
- Intention-to-treat: yes.

**Participants**
- Country: The Netherlands.
- Diagnosis: Gynecologic cancer (cancer of the vulva, cervix, corpus or ovary) or a primary malignancy (with or without metastases) of the testis, skin, bladder, liver, pancreas, colon, breast, or oesophagus.
- Age: mean age experimental group was 54 (SD 15.0) years (range 25 to 85); mean age control group was 53 (SD 16.5) years (range 15 to 93).
- Sex: men and women.
- Ethnicity: not stated.
- Exclusions: inability to speak, read, or write the Dutch language; obvious psychopathology.
- Clinical setting: gynaecology or medical oncology outpatient clinic, Academic Medical Center.

**Interventions**
- Consultation type: patients were aware of their cancer diagnosis and were referred for an initial discussion of possible treatment options. During the recorded consultations, the following topics were usually discussed: reason for referral to a specialist, the specific aspects of the diagnosis, medical history, findings of the physical examination, the proposed treatment policy, prognosis, (short-term) side effects, and other (long-term) consequences of the treatment (eg. sexuality, fertility, and work). The physical examination that took place during these consultations was not recorded for technical and privacy reasons.
- I (n = 105): provided with tape immediately after the consultation.
- C (n = 96): not provided with tape.
- N = (baseline) 201.
- Theoretical basis: not stated.
Outcomes

Timing of outcome assessment: Patients were sent the informed consent form together with the baseline questionnaire a few days before the initial consultation. Questionnaires were sent the following week (T1) and after 3 months (T2).

Psychology: disease specific quality of life (Rotterdam symptom checklist), generic quality of life (Medical Outcome Studies).

Use and opinions of interventions: attitudes toward the intervention.

Information: recall of information.

Satisfaction: patient satisfaction with the audiotaped consultation (Patient Satisfaction Questionnaire), patient satisfaction with medical care (Patient Satisfaction Questionnaire III).

Notes

Power calculation: not stated.

Eleven oncologists (six gynaecologists and five medical oncologists) audiotaped initial consultations with their patients.

Risk of bias

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Reynolds 1981

Methods

Objective: To evaluate the effects of direct questioning, explicit categorisation and consultation audiotapes on patient information levels and satisfaction.

Study design: RCT.

Recruitment: consecutive new referrals.

Randomisation: not stated.

Clinician blind: not stated.

Assessor blind: not stated.

Patient awareness of study: not stated.

Total number approached: not stated.

Number agreed to participate: 42.

Method of analysis: Student’s t-test.

Intention-to-treat: not stated.

Participants

Country: Australia.

Diagnosis: cancers of the lung (9), breast (17), skin (3), lymph (5), colon (2), other sites (6).

Age: mean = 52.7 (SD = 11.5) years, range not stated.

Sex: men and women.

Ethnicity: not stated.

Exclusions: not stated.

Clinical setting: hospital department of medical oncology.

Interventions

Consultation type: all patients included in the study underwent a structured interview before their first appointment with one of two oncologists. All patients’ first consultations were recorded on audiotape.

I (n = 14): patients were informed about their illness using an information handout stating “If you would like to know I will tell you: (1) what is wrong with you and what the diagnosis is; (2) what the treatment will be; (3) what sort of symptoms you may have; (4) what examinations and tests will be necessary; (5) what
Reynolds 1981  (Continued)

can be done for any physical discomfort or pain you might experience; and (6) what the outcome might be”. Detailed information was then presented under each category heading, provided that, in response to a direct question, the patient indicated that he or she would like to receive information about that aspect of the illness or its treatment. At the end of the consultation, patients were given the handout on which the information they wished to receive had been entered during the consultation. They were also provided with a copy of the tape-recording of the consultation.

I 2 (n = not stated): patients were presented with information in an identical manner to group 1, except they were not given the audio-tapes.

C (n = not stated): patients were informed verbally (normal practice) and any direct questions from patients were answered. Neither the written information nor the audio-tapes were given to patients in this group.

N = (baseline) not clear

Theoretical basis: not stated.

Outcomes

Timing of outcome assessment: 5 days and 6 weeks after the consultation
Information: the amount of information desired (instrument not stated); presented (oncologists’ records); and the amount of information recalled in each category (instrument not stated).
Satisfaction: patient satisfaction with the amount of information received (5-point scale).
Use and opinions of audiotapes: patient self-reports during follow-up interviews (specific instrument not stated).

Notes

Power calculation: not stated.

Risk of bias

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Sepucha 2000

Methods

Objective: to assess the effectiveness of an intervention (Consultation recording) designed to improve the quality of medical consultations between breast cancer patients and physicians and, in particular, to assess the effectiveness of the intervention on the quality of treatment decisions, the quality of communication, and the satisfaction of patients and physicians.
Study design: sequential, controlled trial design.
Recruitment: Identified patients through the scheduling system and through physician referral.
Randomisation: not stated.
Clinician blind: no.
Assessor blind: no.
Patient awareness of study: yes. All patients reviewed and signed an informed consent.
Total number approached: 24.
Number agreed to participate: 24.
Method of analysis: nonparametric statistics, one-tailed Wilcoxon rank sum test, Cohen's kappa, two-tailed Wilcoxon rank sum test.
Intention-to-treat: not stated.
Participants

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<th>Country: USA.</th>
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<tbody>
<tr>
<td>Diagnosis: breast cancer (or ductal carcinoma-in-situ).</td>
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<tr>
<td>Age: Intervention group mean = 47 (SD 6.9) years, Control group mean = 48 (SD 6.7) years.</td>
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<tr>
<td>Sex: women.</td>
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<tr>
<td>Ethnicity: predominantly white.</td>
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<tr>
<td>Exclusions: no breast cancer (or ductal carcinoma-in-situ), not able to read and speak English, not consulting one of two physicians (a surgeon or a medical oncologist) about treatment.</td>
</tr>
<tr>
<td>Clinical setting: University of California, San Francisco Carol Franc Buck Breast Care Center</td>
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</table>

Interventions

| Consultation type: Patients completed surveys indicating their current desire for participation in decisions and assessment of decision quality. This was followed by a 30-minute consultation planning session for all patients (control and intervention), at which time a researcher created a flow chart of the patients' specific questions and concerns. Then, the patients repeated the surveys indicating their perceptions of decision quality. |
| I (n = 12): a researcher helped create an agenda, facilitated the discussion, and created a record of the medical consultation between patient and physician (discussing diagnosis and treatment options) in real time using Inspiration software (Inspiration Software Inc, Portland, OR). |
| C (n = 12): a researcher observed the medical consultation but did not participate unless asked to by the patient or physician. |
| N = (baseline) 24. |
| Theoretical basis: not stated. |

Outcomes

| Timing of outcome assessment: Before the medical consultation, the physicians completed a short questionnaire indicating their level of preparedness. Patients completed the Decision Quality Scale before and after the consultation planning session. After the medical consultation, the patients and physicians filled out a satisfaction questionnaire and repeated the decision quality survey. |
| Satisfaction: The University of California San Francisco Satisfaction with Consultation Scale (SWC). |
| Participation: Decision Quality Scale. |

Notes

| Power calculation: not stated. |
| Both physicians saw a comparable number of patients in each group. |
| The short enrolment period was meant to minimize any confounding factors that might be expected in a sequential trial. |
| Because it was impossible for either the investigator or the physicians to be blind to the intervention, precautions were taken to ensure that the interventions were administered without bias favouring either group. |
| The intervention did not significantly increase the time in consultations or significantly affect the number of follow-up consultations before treatment. |
| In the control arm, the patients and physicians did not ask the researcher to participate; as a result, the researcher simply observed these sessions. |
| The intervention was complex, having five steps for the intervention group. Hence, the significant differences in measured outcomes can only be attributed to the intervention as a whole. |
| The small sample size limits the generalisability of the findings |

Risk of bias

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Recordings or summaries of consultations for people with cancer (Review) 33

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### Sepucha 2000 (Continued)

| Allocation concealment? | Unclear | D - Not used |

### Stephens 2007

#### Methods
- **Objective:** To evaluate audio tape recorded consultations at which a new diagnosis of oesophageal or gastric cancer was given to patients with reference to information retention, psychological outcome and socio-economic deprivation.
- **Study design:** RCT.
- **Recruitment:** Patients recruited prospectively from a consecutive series of outpatients newly referred to the oesophagogastric cancer multidisciplinary team. Participants were identified from referral information and approached while in outpatient department waiting for consultation.
- **Randomisation:** Random allocation, stratified for sex, to have consultations audiotaped or not; method not stated.
- **Clinician blind:** Not stated.
- **Assessor blind:** Not stated.
- **Patient awareness of study:** informed consent obtained while awaiting consultation.
- **Total number approached:** 91 patients.
- **Number agreed to participate:** 58 patients (64%).
- **Method of analysis:** Non-parametric tests; grouped data expressed as median (range). Groups compared with Mann-Whitney U test for unpaired data.
- **Intention-to-treat:** Yes.

#### Participants
- **Country:** South Wales, UK.
- **Diagnosis:** Histologically proven oesophageal or gastric carcinoma. Tape group: 16 oesophageal cancer, 15 gastric cancer; Control group: 9 oesophageal cancer, 18 gastric cancer.
- **Age:** Median (range), tape 66 (48 to 88) years, control 69 (49 to 82) years.
- **Sex:** Male and female, m:f ratio tape 22:9, control 21:6.
- **Ethnicity:** Not stated.
- **Inclusions:** Able to speak and write in English, and free of primary or secondary brain disease.
- **Exclusions:** Patients admitted acutely with emergency complications of their tumours.
- **Clinical setting:** outpatient clinic, oesophageal cancer multidisciplinary team, Gwent, South Wales.
- **Deprivation score:** median Welsh Index of Multiple Deprivation score, tape 20.65, control 21.95

#### Interventions
- **Consultation type:** new diagnosis of oesophageal or gastric cancer.
- **Intervention:** Consultation audiotaped and given to patient with general, cancer-site specific leaflet; n = 31 (2 patients refused).
- **Control:** Consultation as usual, given general cancer-site specific leaflet; n = 27.
- **N = 58.**
- **Theoretical base:** Not stated.

#### Outcomes
- **Timing of outcome assessment:** timing unclear: information given during the consultation (control group), attitude to tape questionnaire (tape group); 1 to 2 weeks post-consultation: information recall (both groups); Hospital Anxiety and Depression (HAD) questionnaire (both groups)
- **Use and opinions of intervention:** attitude to tape questionnaire (tape group only).
- **Satisfaction with consultation:** attitude to information provided in the consultation (no further details) (control group only).
- **Information recall:** individual items of information recalled successfully (no further details) (both groups).
Psychological adjustment: Hospital Anxiety and Depression Scale (HAD) (Zigmond 1983) (both groups)

Notes
Power calculation: based on literature review and pilot study; 41 patients needed to give 90% power to detect a difference with $P < 0.05$ based on indications that 20% of patients expected to forget key facts from cancer consultation.
The prognostic categories of the two groups were well matched: 19% and 22% of patients in the tape and the control group respectively had good prognoses based on perceived preoperative radiological stage.

Risk of bias

<table>
<thead>
<tr>
<th>Item</th>
<th>Authors' judgement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation concealment?</td>
<td>Unclear</td>
<td>B - Unclear</td>
</tr>
</tbody>
</table>

Tattersall 1994

Methods
Objective: To compare the effects of consultation audiotapes versus individualised summary letters on patients’ information recall, anxiety and depression, satisfaction, and use and preferences after their first consultation with a medical oncologist.
Study design: RCT (cross-over).
Recruitment: not stated.
Randomisation: not stated.
Clinician blind: yes.
Assessor blind: not stated.
Patient awareness of study: not stated.
Total number approached: not clear.
Number agreed to participate: 182.
Method of analysis: Variance-ratio (or F) test; Student’s t test; McNemar test, chi-squared test, logistic regression analysis.
Intention-to-treat: not stated.

Participants
Country: Australia.
Clinical setting: University teaching hospital.
Age: range 16 to 80 years.
Sex: men and women.
Ethnicity: not stated.
Exclusions: non-English speaking, advanced incapacity, unavailability for duration of follow-up.

Interventions
Consultation type: first consultation with medical oncologist.
Consultations were audiotaped. Immediately after the consultation, the medical oncologist prepared a letter summarising the most important or salient points covered.
I 1 (n = 94): patients were given the tape immediately, then the letter seven to ten days after the first follow-up.
I 2 (n = 88): the letter was posted the day after the consultation, then the tape was sent seven to ten days after the first follow-up.
N = (baseline) 182.
Theoretical basis: not stated.
Outcomes

Timing of outcome assessment: 7 to 10 days after the consultation and 7 to 10 days after the first outcome assessment.
Psychology: anxiety and depression (14-item HADS).
Information: patient recall of information judged salient by oncologist (derived from Dunn 1993).
Use and opinions: patient use of tapes and letters (telephone interview).
Satisfaction with tapes and letters (content analysis of patients' comments: questionnaire derived from Dunn 1993).
Patient ranking of six communications options (telephone interview)

Notes

Power calculation: not stated.
A single oncologist was involved in all consultations.
A difference in depression was observed between experimental conditions at baseline (t = 1.95; P < .05). The difference between anxiety scores at baseline was nearly significant (t = 1.89; P = .061). This suggests that the samples were not comparable at baseline

Risk of bias

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<thead>
<tr>
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<tbody>
<tr>
<td>Allocation concealment?</td>
<td>Unclear</td>
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</tr>
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</table>

Characteristics of excluded studies [ordered by study ID]

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ah-Fat 1998</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Bell 2003</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Bowden 2003a</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Bowden 2003b</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Butt 1977</td>
<td>Uncontrolled trial of consultation audiotapes which does not address a cancer population</td>
</tr>
<tr>
<td>Deutsch 1992</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Eden 1993</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Ellis 1979</td>
<td>Does not address a cancer population.</td>
</tr>
<tr>
<td>Gent 2003</td>
<td>Historical control group.</td>
</tr>
<tr>
<td>Haslop 2005</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Reference</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hogbin 1989</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Johnson 1991</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Knox 2002</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Liddell 2004</td>
<td>Not specific to cancer</td>
</tr>
<tr>
<td>Lobb 2002</td>
<td>Genetic counselling, not consultation with practitioner.</td>
</tr>
<tr>
<td>Ong 1995</td>
<td>Not a controlled trial.</td>
</tr>
<tr>
<td>Rosenbaum 1986</td>
<td>Description of consultation audiotape use in oncology.</td>
</tr>
<tr>
<td>Rutherford 1991</td>
<td>Uncontrolled trial of sending renal patients a copy of correspondence sent by the consultant to the referring GP</td>
</tr>
<tr>
<td>Rylance 1992</td>
<td>Uncontrolled trial of giving consultation tapes to parents of general paediatric and lipid and metabolic specialist paediatric outpatients</td>
</tr>
<tr>
<td>Sepucha 2003</td>
<td>Intervention not a recording of consultation.</td>
</tr>
<tr>
<td>Tattersall 1990</td>
<td>Study of diabetic patients receiving a copy of the letter sent by the consultant to the referring GP</td>
</tr>
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</table>
## DATA AND ANALYSES

### Comparison 1. Summary letter versus control

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
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<tbody>
<tr>
<td>1 Information recall</td>
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<td>2 Use and opinions of intervention</td>
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### Comparison 2. Written summaries as part of a five-step intervention versus only a visit preparation session

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### Comparison 3. Information plus consultation tape versus information alone versus control

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<tr>
<th>Outcome or subgroup title</th>
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### Comparison 4. Information package, question list, support and consultation tape, versus information package alone

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### Comparison 5. Consultation tape versus control

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<td>5 Psychological adjustment</td>
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### Comparison 6. Consultation tape versus general tape versus no tape

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<tr>
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### Comparison 7. Consultation tape versus general tape versus both

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### Comparison 8. Consultation tape versus no tape versus choice of receiving tape

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<td>5 Psychological adjustment</td>
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</table>
Comparison 9.  Consultation tape in addition to written recommendations versus written recommendations only

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</table>

Comparison 10.  Consultation tape followed by summary letter versus summary letter followed by consultation tape

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
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<th>Effect size</th>
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<td>4 Psychological adjustment</td>
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</tr>
</tbody>
</table>

Analysis 1.1.  Comparison 1 Summary letter versus control, Outcome 1 Information recall.

**Information recall**

| Study          |  
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Damian 1991    | No statistically significant difference was found in percentage of items recalled by the two groups, although letter group patients were given more items to remember than no-letter group patients. Median (range) number of recorded points per patient: I = 6 (3 to 13), C = 5 (4 to 9). Amount of information recalled: I = 85% (50 to 100), C = 75% (50 to 100).
|                | There was no statistically significant relation between recall and interval from consultation to follow-up.
|                | Control group patients were more likely than letter group patients to wrongly remember items: 7/24 (29.2%) control group patients recalled at least 1 piece of wrong information compared with 2/24 (8.3%) in the letter group |

Analysis 1.2.  Comparison 1 Summary letter versus control, Outcome 2 Use and opinions of intervention.

**Use and opinions of intervention**

| Study          |  
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Damian 1991    | 20/24 (83%) people in the intervention group found their letters useful to clarify, improve understanding, and provide a permanent record of, the consultation. Patients in the intervention group who received bad news found the letter more useful to understand and remember their consultation than did patients receiving good news. 10/12 (83%) people in the intervention group who classified their consultations as “bad news” were pleased to have received their letter, although 5/12 (42%) said that it had distressed them. 16/12 (67%) people in the control group thought that a letter outlining their consultation would be useful, most even if it contained “bad news”. Participants |

Recordings or summaries of consultations for people with cancer (Review)

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Use and opinions of intervention  (Continued)

read their letters an average of 2.6 times (range 1 to 8), and 20/24 (83%) had shown it to at least 1 other person - e. g., their spouse, friends, other family members, or their general practitioner.

16 (67%) CG patients thought that a letter outlining their consultation would be useful, most even if it contained “bad news”.

49/62 (79%) of referring doctors (40 general practitioners, 22 specialists) were sure that a letter outlining the oncology consultation would be useful to patients. 11/62 (17.7%) were sure that it would not be useful, and 2 (3.2%) were unsure. 30/40 (75%) general practitioners and 19/22 (86%) specialists thought that copies of the letters should be sent to the patients’ medical advisors.

### Analysis 1.3. Comparison 1 Summary letter versus control, Outcome 3 Satisfaction with consultation.

#### Satisfaction with consultation

<table>
<thead>
<tr>
<th>Study</th>
<th>People in the intervention group tended to be more satisfied than people in the control group with the amount of information given (median scores on a 5-point scale: I = 5, C = 4; P = 0.014). Total satisfaction scores for people in the intervention group were higher than for those in the control group (total median scores: I = 32.5, C = 30; P = 0.014. Most of those with bad news consultations were pleased to have received the letter (10/12, 83%), although 5/12 (42%) reported that it had been distressing.</th>
</tr>
</thead>
</table>

### Analysis 2.1. Comparison 2 Written summaries as part of a five-step intervention versus only a visit preparation session, Outcome 1 Satisfaction with consultation.

#### Satisfaction with consultation

<table>
<thead>
<tr>
<th>Study</th>
<th>The data from the Satisfaction with Consultation scale suggests that patients’ satisfaction is higher with the intervention than with the control. The median Patient Satisfaction with Consultation score is 11 for the intervention group versus 7 for the control group, for an estimated difference of 4 (P = 0.073). Further, 75% of the patients in the intervention group scored 10 or higher on the SWC scale, whereas less than 17% of the control scored 10 or higher. Given the complexity of the intervention is it impossible to attribute these findings to the written summary alone.</th>
</tr>
</thead>
</table>

### Analysis 2.2. Comparison 2 Written summaries as part of a five-step intervention versus only a visit preparation session, Outcome 2 Participation.

#### Participation

<table>
<thead>
<tr>
<th>Study</th>
<th>No significant differences were found between the groups on the Patient Decision Scales 1 and 2. After the consultation, patients in both arms demonstrated an increase in decision quality. Compared with the control group, the intervention group achieved a significantly higher median score on the Patient Decision Scale 3 (9.5 versus 13, respectively; estimated difference 3.5; P = 0.008).</th>
</tr>
</thead>
</table>
The data also suggest that the mean increase in decision quality is larger in the intervention group than in the control. The mean change, Patient Decision Scale 3 minus Patient Decision Scale 2, is 9.7 points for the intervention and only 6.6 points for the control, for an estimated difference of 3.1 (P = 0.057). Owing to the complex intervention, however, it is impossible to attribute this behaviour to the written summary alone.

**Analysis 3.1.** Comparison 3 Information plus consultation tape versus information alone versus control, Outcome 1 Information recall.

**Information recall**

| Study          | Participants in the control group recalled a greater mean percentage of presented facts than did those in the intervention groups: (at 5 days) I1 and I2 = 19.5/28.9 (68.7%), C = 14.9/18.2 (79.7%); t (40) = 2.0637, P < 0.05; (at 6 weeks) I1 and I2 = 19.6/28.9 (68.9%), C = 15.9/18.2 (84.4%); t (40) = 3.2503, P < 0.01. However, people in the control group were presented with fewer facts which they desired than were people in the intervention groups (61% and 100%, respectively) |

**Analysis 3.2.** Comparison 3 Information plus consultation tape versus information alone versus control, Outcome 2 Use and opinions of intervention.

**Use and opinions of intervention**

| Study          | All participants and/or their families said they had found the consultation tapes of value |

**Analysis 3.3.** Comparison 3 Information plus consultation tape versus information alone versus control, Outcome 3 Satisfaction with consultation.

**Satisfaction with consultation**

| Study          | No significant differences were found between the groups. All groups were highly satisfied |

**Analysis 4.1.** Comparison 4 Information package, question list, support and consultation tape, versus information package alone, Outcome 1 Use and opinions of intervention.

**Use and opinions of intervention**

| Study          | 26/30 (86.7%) people in the intervention group had their consultation audiotaped, of whom 22/30 (73.3%) listened to their tape from 1 to 4 times. 15/30 (50%) used the tape to review the consultation and to share information with their family. 8/30 (26.7%) used the tape to only review the consultation, and 1/30 (3.3%) used it only to share |
Use and opinions of intervention  

<table>
<thead>
<tr>
<th>Study</th>
<th>Analysis 4.2. Comparison 4 Information package, question list, support and consultation tape, versus information package alone, Outcome 2 Participation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davison 1997</td>
<td>A significantly higher proportion of participants in the intervention group assumed a more active role in treatment decision making than did participants in the control group. Owing to the complex intervention, however, it is impossible to attribute this behaviour to the audiotape alone.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study</th>
<th>Analysis 4.3. Comparison 4 Information package, question list, support and consultation tape, versus information package alone, Outcome 3 Psychological adjustment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davison 1997</td>
<td>No significant differences were found between the groups in state anxiety or depression.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Study</th>
<th>Analysis 5.1. Comparison 5 Consultation tape versus control, Outcome 1 Information recall.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ford 1995</td>
<td>(From McHugh paper): People in the intervention group recalled more of the information given than did people in the control group on 5 out of 9 components of the information retention questionnaire (Tests and results: I = 91%, C = 67%; p &lt; 0.05; Name of treatment: I = 100%, C = 81%; p &lt; 0.05; Other treatments: I = 94%, C = 62%; p &lt; 0.05; Side-effects of treatment: I = 89%, C = 67%; p &lt; 0.05; Specific instructions about self-care: I = 85%, C = 56%; p &lt; 0.05)</td>
</tr>
<tr>
<td>Hogbin 1992</td>
<td>No significant difference was found between the groups in their understanding of information. More people in the control group than in the intervention group went to see their GP: I = 37%, C = 65%; chi squared = 4.31, p &lt; 0.05)</td>
</tr>
<tr>
<td>North 1992</td>
<td>Participants in the intervention group recalled more information than did participants in the control group (mean number of items recalled: I = 9.33, SD = 1.64; C = 4.44, SD = 2.13; ANOVA, F = 51.21, P &lt; 0.0001)</td>
</tr>
<tr>
<td>Ong 2000</td>
<td>A main effect of the intervention was found for all information categories, indicating that patients provided with the tape were able to recall more information regarding all topics discussed during the consultation (P &lt; 0.001; except for trial procedure and chemotheraphy, P &lt; 0.01). Also, the tape group recalled more information at both follow-up assessments</td>
</tr>
</tbody>
</table>
Information recall  (Continued)

| Study          | Patients who had received taped consultations were less likely to forget key facts regarding their diagnosis and treatment options compared with patients who had not received a tape (0 versus 9 patients (33%), chi-square = 11.518, df 1, P = 0.001). Specific differences were: name of diagnosis (0 versus 2 patients (7%)), details of investigations and results (0 versus 3 patients (11%)), possible alternative treatments (0 versus 1 patient (4%)), side effects of treatment (0 versus 3 patients (11%)). Deprivation was not associated with information retention (Mann Whitney U = 200.5, P = 0.667) |

Analysis 5.2. Comparison 5 Consultation tape versus control, Outcome 2 Use and opinions of intervention.

Use and opinions of intervention

| Study          | (From McHugh 1995 paper): Attitudes to tape data were available for 39/46 (85%) of participants in the intervention group at stage 3. All of these had played the tape at least once: 29/38 (76%) reported that it was helpful, 6/38 (16%) that it was upsetting. 34/36 (94%) found that the tape helped them remember facts they had forgotten since the interview. Attitudes to tape data were available for 39/63 (62%) of participants in the intervention group at stage 3. All of these had played the tape at least once. 29/39 (74.3%) reported that it was helpful, 6/39 (15.4%) that it was upsetting. 34/39 (87.1%) found that the tape helped them remember facts they had forgotten since the interview. |

| Study          | The tapes were played on average 4.09 times (range 1 to 10). No significant correlation was found between the number of times that the tapes were played and psychological morbidity. 28/35 (80%) of people in the intervention group had listened to the tape with somebody else (partners, family members and friends). 1/35 (2.8%) had played it to her general practitioner. 5/35 (14.3%) thought the tape contained information that they had forgotten and 30/35 (86%) thought it was very helpful. 5/35 (14.3%) of patients felt that they wanted more details. Only 1/35 (2.8%) one did not understand all that was mentioned on the tape. Although the consultation involved an explicit diagnosis of cancer, only 6/35 (17.1%) said they were initially upset at hearing the consultation again. |

| Study          | All participants in the intervention group listened to the tape on average about 4 times during the week between intervention and follow-up. 17/18 (94.4%) expressed positive feelings about their tapes; 11/18 (61.1%) reported that it helped them remember information and aided their decision making regarding treatment; 5/18 (27.8%) that it enabled other family members to listen to the interview, and 2/18 (11.1%) that it made them feel less anxious. There were no negative responses. In 17/18 (94.4%) cases other family members listened to the tape with no adverse effects and positive reports. Several patients used the tape to explain their illness to their family and 3/18 (16.7%) patients played tapes to, and discussed them with their general practitioners. These general practitioners reported that they found it helpful to know precisely what the patient had been told at their consultations. 8/16 (50%) participants in the control group said that it would be useful to have their consultations recorded, and 8/16 (50%) said that it would not be useful. |

| Study          | Experimental group: After 1 week, 77/103 (75%) of patients who were interviewed listened to the tape, whereas 29 patients (32%) listened between the first and second follow-up assessment. On average, they listened 2.1 times (range 1 to 15 times) at T1 and 2.2 times (range 1 to 8 times) at T2. After 1 week, 45/77 (58%) patients listened to the tape together with their partner, and 17 patients listened with their children. Fifteen patients shared the tape with other relatives and/or close friends. One patient gave the tape to the referring oncologist. Also after 3 months, most patients (n = 22) shared the tape with their partner and/or their children. Some shared the tape with other relatives and/or close friends (n = 7). One patient gave the tape to
Use and opinions of intervention

(Continued)

the general practitioner. After 1 week, 47/77 (61%) patients who listened to the tape found that the tape contained information they had forgotten. Eleven patients found that the tape contained upsetting information, whereas 41 patients (53%) found the information on the tape reassuring. After 3 months, half of the patients (14 of 29) found the tape containing both forgotten information and reassuring information. One patient found the information on the tape upsetting. After 1 week, the tape facilitated communication with relatives for 39/77 (51%) patients who listened to the tape. For 33 patients (43%), the tape prompted additional questions regarding their illness and its treatment. After 3 months, the tape facilitated communication with relatives for the majority of patients (18 of 29). Overall, most patients (96% at T1 and 98% at T2) were positive about the intervention and would recommend the intervention to cancer patients (93% at T1 and 96% at T2).

Control group:

Eighty-seven patients (92%) were positive about the concept of providing cancer patients with the taped consultation. After 3 months, 78/82 (95%) of the interviewed patients were positive about this intervention. When offered the taped consultation after 3 months, the majority of patients (77%) still wished to receive it.

Two patients who had had their consultation tape recorded elected not to listen to their tape. 28 of the 31 patients (90%) who received a tape found the experience helpful. The median number of times that patients listened to their tapes was 1 (range 0 to 10). 20 patients played their tapes to relatives, 6 played their tapes to friends, and 3 to their GP. One patient reported being upset by the information contained on the tape. This did not prevent the patient from re-listening to the tape in full several times and commenting that the tape was extremely helpful in reaching a decision regarding treatment.

The tape recording did not influence patients’ decisions on whether or not to undergo surgery (tape 36% versus no tape 37%, chi-square 0.015, df 1, P = 0.902)

Analysis 5.3. Comparison 5 Consultation tape versus control, Outcome 3 Satisfaction with consultation.

Satisfaction with consultation

Study

Ong 2000

A main effect of the intervention was found (F=2.39, P < 0.05), indicating that patients provided with the taped consultation were more satisfied than patients allocated to the control group. Univariate analysis revealed that the tape group was more satisfied with the taped consultation at both follow-up moments (P < 0.01) and with interpersonal aspects of medical care and medical care in general after 1 week (P < 0.05)

Stephens 2007

All 27 control patients felt that the information given at their consultation had been sufficient, but when asked to comment, 2 patients wanted more information about the duration of any possible surgery and quality of life afterwards

Analysis 5.4. Comparison 5 Consultation tape versus control, Outcome 4 Participation.

Participation

Study


Participation (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Ford 1995</td>
<td>No significant differences were found between the groups in the mean number of questions asked during the first or second consultation. However, more participants in the intervention group asked for clarification of specific details at the second consultation than did participants in the control group (I = 77%, C = 57%; chi-squared = 4.1; P = 0.04). During their second consultation, more participants in the control group requested information already supplied to them in their first consultation than did participants in the intervention group (C = 61%, I = 39%; c2 = 3.7; P = 0.05). No significant differences were found between the groups in the ratios of patient versus clinician talk between the 1st and 2nd consultation.</td>
</tr>
<tr>
<td>McHugh 1995</td>
<td>The psychological morbidity of participants with poor prognoses in the tape group increased compared to participants in the tape group with good prognoses and to participants with good or poor prognoses in the control group (tape group; good prognosis mean change: -8.0 (95% CI -12 to -3.9); tape group; poor prognosis mean change: 5.3 (95% CI -1.7 to 12); control group; good prognosis mean change: -2.7 (95% CI -8.2 to 2.8); control group; poor prognosis mean change: -6.3 (95% CI -15 to 2.6); F = 8.34, P = 0.005). Patients with partners (n = 71) improved on the GHQ scale significantly more than did those without partners (n = 29): mean change partners -4 (95% CI 6.7 to 1.7) versus no partner 1 (95% CI -3.2 to 5.5); F = 5.25, P = 0.02.</td>
</tr>
<tr>
<td>Hogbin 1992</td>
<td>No significant differences were found between the groups at either stages 2 or 3.</td>
</tr>
<tr>
<td>North 1992</td>
<td>No significant differences were found between the groups in anxiety or depression on the Hospital Anxiety and Depression Scale.</td>
</tr>
<tr>
<td>Ong 2000</td>
<td>The results show no main effect of the intervention on quality of life (F = 0.87, P = 0.58). Rather, an effect of time was observed, with patient psychological distress, mental health and perceived health improving.</td>
</tr>
<tr>
<td>Stephens 2007</td>
<td>The median HAD A score for patients who received an audio-taped consultation was 6 (range 0 to 21), compared with 5 (2 to 14) for control patients (P = 0.375). The median HAD D score for patients who received an audio-taped consultation was 3 (0 to 23), compared with 4 (0 to 10) for control patients (P = 0.838). The HAD scores were not related to the diagnosis, stage of disease, or overall prognosis. There was a strong trend towards higher HAD A scores for female patients who had received a tape compared with male patients who had received a tape (HAD A female 10 (1 to 21) versus male 5.5 (0 to 16), P = 0.064). The median HAD A score for females in the tape group (10 (1 to 21)) was twice that of females in the control group (5.5 (2 to 14)), although this did not reach statistical significance (P = 0.388). There was no significant difference in deprivation scores between audio-taped patients (20.65 (4.48 to 60.37), P = 0.88) and control patients (21.95 (3.29 to 63.71), P = 0.88). The degree of deprivation correlated significantly with</td>
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</table>
HAD A scores for control patients, with patients from more deprived geographical areas scoring higher levels of anxiety (Spearman's rho = 0.40, P = 0.039). There was no significant correlation between the degree of deprivation and HAD A scores for audiotaped patients (rho = 0.007, p = 0.972). Deprivation scores did not correlate with HAD D scores for either control patients (rho = 0.11, p = 0.114) or audio taped patients (rho = 0.166, p = 0.371).

**Analysis 6.1. Comparison 6 Consultation tape versus general tape versus no tape, Outcome 1 Information recall.**

**Information recall**

<table>
<thead>
<tr>
<th>Study</th>
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<tbody>
<tr>
<td>Dunn 1993</td>
<td>Consultation tapes did not improve recall compared to no tape. However, participants who received the general information tape recalled fewer items of information compared to those who received the consultation tape. This difference reached statistical significance when the analysis included only those who actually listened to the tape (I1 = 29.8%, I2 = 22.6%; P &lt; 0.05)</td>
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**Analysis 6.2. Comparison 6 Consultation tape versus general tape versus no tape, Outcome 2 Satisfaction with consultation.**

**Satisfaction with consultation**

<table>
<thead>
<tr>
<th>Study</th>
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<tbody>
<tr>
<td>Dunn 1993</td>
<td>People in the consultation tape group were more satisfied than people in the general tape group with their tapes (I1 = 61.0%, I2 = 42.7%; P = &lt; 0.05). Satisfaction with the consultation increased linearly with more individualised feedback (C = 85.3%, I2 = 87.2%, I1 = 91.0%; P &lt; 0.05). Outcomes for patients with breast cancer were similar regardless of group assignment. Patients with cervical cancer who received the general tape were less satisfied with the consultation itself (61% versus 93%, respectively; P &lt; 0.01). All patients with cervical cancer listened less frequently to either tape (1.2 times versus 1.4 for breast and 2.4 for all other cancers; P &lt; 0.05) and those who received the general tape scored lower on psychological adjustment (47% versus 62% for the consultation tape; P &lt; 0.05)</td>
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</table>

**Analysis 6.3. Comparison 6 Consultation tape versus general tape versus no tape, Outcome 3 Psychological adjustment.**

**Psychological adjustment**

<table>
<thead>
<tr>
<th>Study</th>
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<tbody>
<tr>
<td>Dunn 1993</td>
<td>No significant differences were found between the groups.</td>
</tr>
</tbody>
</table>
Analysis 7.1. Comparison 7 Consultation tape versus general tape versus both, Outcome 1 Information recall.

**Information recall**

<table>
<thead>
<tr>
<th>Study</th>
<th>Mean scores for Perception of Being Informed (PPBI subscale of Informed Consent Questionnaire) were generally high with no significant differences between the groups: consultation audiotape (26.6 (SD 6.2)) versus standardized audiotape (28.5 (SD 6.6)) versus both (30.5 (SD 9.6))</th>
</tr>
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<tr>
<td></td>
<td>Coding of the consultation audiotapes using a 14-item scheme based on the PPBI subscale showed a mean score of 8.7/14 versus 13/14 for the standardized audiotape.</td>
</tr>
<tr>
<td></td>
<td>Mean scores for knowledge of information (PKI subscale of Informed Consent Questionnaire) were generally high with no significant differences between the groups: consultation audiotape (15.0 (SD 1.9)) versus standardized audiotape (14.4 (SD 2.2)) versus both (14.8 (SD 1.8))</td>
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</table>

Analysis 7.2. Comparison 7 Consultation tape versus general tape versus both, Outcome 2 Use and opinion of intervention.

**Use and opinion of intervention**

<table>
<thead>
<tr>
<th>Study</th>
<th>The entire consultation was listened to an average of 1.3 times (SD 0.9), and a portion was used on average 1.1 times (SD 1.0). The entire standardized audiotape was listened to an average of 1.4 times (SD 0.7); a portion was used a mean of 0.8 times (SD1). Patients who received both audiotapes listened to the entire consultation tape an average of 1.1 times (SD 0.8), a portion of the consultation audiotape 0.8 times (SD 1.2), the entire standardized audiotape an average of 1.2 times (SD 0.6), and a portion of the standardized audiotape an average of 0.2 times (SD 0.6). Among all patients, 47.5% preferred to have both audiotape types, 39.3% preferred the consultation audiotape and 11.5% preferred the standardized audiotape. 1.6% had no preference. Among patients who received both audiotapes, 50% preferred the consultation audiotape and 18% preferred the standardized audiotape. 32% had no preference. Results suggest that patients preferred the consultation audiotape over the standardized audiotape, but this was not statistically significant (chi-squared = 3.27; df 1; P = 0.071)</th>
</tr>
</thead>
</table>

Analysis 7.3. Comparison 7 Consultation tape versus general tape versus both, Outcome 3 Satisfaction with consultation.

**Satisfaction with consultation**

<table>
<thead>
<tr>
<th>Study</th>
<th>Mean scores for satisfaction with communication during the consultation (Patient Perception Scale) were generally high with no significant differences between the groups: consultation audiotape (12.3 (SD 4.0)) versus standardized audiotape (14.1 (SD 4.9)) versus both (13.7 (SD 5.2))</th>
</tr>
</thead>
</table>
**Analysis 8.1. Comparison 8 Consultation tape versus no tape versus choice of receiving tape, Outcome 1**

**Information recall**

<table>
<thead>
<tr>
<th>Study</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Hack 1999</td>
<td>With respect to the content of the information about illness and treatment that the physicians imparted during the consultations, the physicians at each of the three geographic locations reviewed information in almost all the following categories: diagnosis, treatment alternatives, treatment procedures, treatment side effects, and prognosis. Overall, patients' recall of the discussion of these categories of information during the consultation was high at the six-week follow-up: The mean score per item was 4.3 on the five-point scale. This score indicated that most patients were highly confident that the five categories of treatment information were discussed. Few inaccuracies were noted when they were asked to recall, in detail, the treatment information that was conveyed. Despite the small number (18) of patients with prostate cancer, a Kruskal-Wallis analysis of variance (ANOVA) showed statistically significant differences between the three groups of patients. Patients who received the audiotape by choice recalled a more thorough consultation than did patients who did not receive the audiotape (chi-squared = 7.70, P &lt; 0.05)</td>
</tr>
<tr>
<td>Hack 2003</td>
<td>Only 4 of the T3 patients declined the audiotape. Because these patients were a small percentage of those patients offered a choice (&lt; 3%), they were removed from further analysis. Patients who received the audiotape reported having been provided with significantly more information about the side effects of treatment (mean score 4.68; SD, 0.88) than patients who did not receive the audiotape (mean score 4.46; SD 1.13; F = 7.03; P = 0.01). There was no statistically significant differences between the two audiotape conditions (T2 versus T3) with respect to the patients' perception of having been informed. Regression analysis showed no association between decisional role selection and perception of having been informed</td>
</tr>
<tr>
<td>Hack 2007a</td>
<td>Patients who received the consultation audiotape reported having been provided with significantly more information about treatment alternatives (mean score 4.73; SD 0.74) than patients who did not receive the audiotape (mean score 4.56; SD 1.03; F = 4.27, P = 0.04). Patients who received the audiotape also reported having been provided with significantly more information about the side effects of treatment (mean score 4.63; SD 0.87) than patients who did not receive the audiotape (mean score 4.37; SD 1.17) (F = 6.07, P = 0.01). In addition, the total score difference between the audiotape (mean score 21.83; SD 3.78) and non-audiotape (mean score 21.01; SD 4.31) groups was statistically significant (F=4.31; P=0.04), indicating that those patients who received the audiotape felt that they had been provided with more information overall. The effect sizes for these three statistically significant findings were 0.09, 0.13 and 0.10, respectively. The test of the cognitive dissonance hypothesis revealed no statistically significant differences between the two audiotape conditions (assigned vs. chosen) with respect to the patients' perception of having been informed. The regression analysis showed a significant association between decisional control and perception of having been informed, at 12 weeks post-consultation. Active and collaborative roles were significantly predictive of feeling informed about treatment side effects, likelihood of cure, additional sources of information, and overall treatment and illness information</td>
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</table>
Use and opinions of intervention

<table>
<thead>
<tr>
<th>Study</th>
<th>Use and opinions of intervention</th>
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</thead>
<tbody>
<tr>
<td>Hack 1999</td>
<td>The use of the audiotape differed in group 2 (no choice) and group 3 (choice). First, the patients in group 3 were more likely to listen to a portion of the tape than were the patients in group 2 (83% versus 55%, respectively). Second, the patients in group 3 listened to the entire tape an average of 2.5 times more often than did the patients in group 2, who listened to the entire tape an average of only 1 time. These two findings approached statistical significance despite the small sample.</td>
</tr>
<tr>
<td>Hack 2003</td>
<td>A total of 323 patients received an audiotape of their primary consultation. 196/323 patients (60.7%) listened to at least a portion of the audiotape during the 12 week post consultation period. Most (189; 96.4%) listened to the entire audiotape, and many of these listened to portions too. 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. Patients rated the audiotape intervention highly. Of the 196 patients who listened to the audiotape, 83 (42.4%) rated the intervention 100 out of a possible 100. There were 157 (80.1%) patients who rated the intervention 75 points or higher. Five (2.6%) patients rated the intervention 49 points or fewer. The mean audiotape favorableness rating was 83.9 out of 100 (SD 19.6), indicating highly positive regard for the intervention.</td>
</tr>
<tr>
<td>Hack 2007a</td>
<td>A total of 214 patients received an audiotape of their primary consultation. Of these, 140 (65.4%) listened to the entire audiotape during the 12-week post-consultation period, while 74 (34.6%) did not listen to the audiotape at all. Of the 140 patients who listened to the entire tape, 117 (83.6%) listened additionally to portions of the audiotape. Patients listened to the entire tape a mean of 2.8 times; a portion of the tape 3.0 times. Of those patients who received the audiotape, 123 (57.4%) 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 2.0. Patients rated the audiotape intervention highly. Of the 140 patients who listened to the audiotape, 59 (27.6%) rated the intervention 100 out of a possible 100. There were 100 (46.7%) patients who rated the intervention 75 points or higher. One patient (0.5%) rated the intervention 49 points or fewer. The mean audiotape favorableness rating was 83.0 out of 100 (SD 19.2), indicating highly positive regard for the intervention. No significant difference was shown between the two groups (choice versus assigned) that received the audiotape with respect to the number of patients who listened to the audiotape, the number of times the patient listened to the audiotape, and the number of different people who listened to the audiotape.</td>
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Satisfaction with consultation

<table>
<thead>
<tr>
<th>Study</th>
<th>Satisfaction with consultation</th>
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<tbody>
<tr>
<td>Hack 1999</td>
<td>Patients' reports of satisfaction with patient-physician communication during the consultation dropped from being extremely high immediately after the consultation to being moderate to high six weeks later. A ceiling effect, however, was evident for the satisfaction scores immediately after the consultation. A ceiling effect also was noticed in the patients' uniformly high scores on their physician's likability and expertise. Overall, patients expressed strong support.</td>
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</table>
Satisfaction with consultation (Continued)

for receiving the audiotape. All patients offered a choice regarding whether they wanted the audiotape decided to receive the tape.

For the total sample, there was a statistically significant correlation between recall at follow-up about the extent of the discussion about treatment-related concerns during the consultation and the degree of follow-up reports of satisfaction with the consultation ($r = 0.41$, $P < 0.05$). Patients who recalled an extensive discussion of treatment information were most highly satisfied with patient-physician communication during the consultation. A more detailed analysis by disease site showed this finding to be statistically significant for male patients ($r = 0.58$, $P < 0.05$) but not for female patients.

Hack 2003

No difference in satisfaction with communication with the oncologist was detected in comparisons between those who received an audiotape (T2 and T3) and those that did not (C and T1); nor did the audiotaping process show any effects (C versus T1). There was no significant difference in patient satisfaction between the two groups (T2 versus T3) that received the audiotape (test of the cognitive dissonance hypothesis).

Regression analysis showed no association between decisional role selection and satisfaction with communication with the oncologist.

Hack 2007a

A comparison of the two groups who received a copy of the audiotape (assigned tape; chose tape) with the two groups who did not receive the audiotape (assigned to not receive tape; standard care control) revealed no significant difference in patient satisfaction with communication with oncologist at 12 weeks post-consultation. An examination of the impact of the audio-taping process (standard care control vs. assigned to not receive tape) also produced no statistically significant differences. The final comparison showed no significant difference between the two groups (choice vs. assigned) that received the audiotape with respect to patient satisfaction.

The regression analysis showed a significant association between decisional control and satisfaction with communication with the oncologist, at 12 weeks post-consultation. Patients who indicated at follow up that they had assumed a collaborative role reported being significantly more satisfied with communication with their oncologist at 12 weeks post-consultation than patients who said they had played a passive role.

**Analysis 8.4. Comparison 8 Consultation tape versus no tape versus choice of receiving tape, Outcome 4 Participation.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hack 1999</td>
<td>With respect to patients’ roles in decision-making, women reported before the consultation that they preferred a collaborative role in decision-making, whereas the men preferred a passive role. When asked at the six-week follow-up about the role they had actually assumed in decision-making during the consultation, the majority of men and women indicated they had played an active role. However, the independent coders determined that the majority of both women and men actually had played a passive role. The women asked more questions than the men did, averaging 2.8 general questions about their illness and 5.3 treatment-specific questions (total=8.1 questions). The men asked an average of 1.4 general questions about their illness and 3.5 treatment-specific questions (total=4.9 questions)</td>
</tr>
<tr>
<td>Hack 2003</td>
<td>Patients’ preferred (preconsultation) and assumed (postconsultation) roles in decision making were measured. Slightly more than half of all patients (52.4%) preferred a collaborative role as they entered the consultation room. The percentage decreased to 40.6% after the consultation when assumed roles (i.e. the role that they actually play rather</td>
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</table>
Participation (Continued)

than what they say they prefer to play) were measured. The percentage of patients who endorsed an active role increased from preconsultation preferred role (23.6%) to postconsultation assumed role (34.8%). The pre- and postconsultation treatment role percentages were similar for patients who chose the passive role (24.0% v. 24.6%)

Hack 2007a

Approximately half of all patients (49.2%) preferred a collaborative role as they entered the consultation room. This percentage fell to 43.3% after the consultation when assumed roles were measured, and fell further to 31.9% at 12 weeks post-consultation. This 17.3% drop in the endorsement of the collaborative role from pre-consultation to 12 weeks post-consultation was accompanied by an increase in the relative percentage of patients over this time period who endorsed either an active (from 30.6 to 39.7%) or passive role (from 20.2 to 28.4%).

The regression analysis showed a significant association between decisional control and perception of having been informed, satisfaction with communication with the oncologist, and quality of life at follow up, but was not significantly related to follow-up mood state, at 12 weeks post-consultation.

Analysis 8.5. Comparison 8 Consultation tape versus no tape versus choice of receiving tape, Outcome 5

Psychological adjustment

Study

Hack 1999

The men's anxiety scores remained fairly constant at the 'somewhat' level across all three assessments, whereas the women's scores decreased from a point midway between 'somewhat' and 'moderately' before the consultation to 'somewhat' at follow-up. This decrease in anxiety did not reach statistical significance, however

Hack 2003

No difference in any aspect of the profile of mood states, or in any quality of life scales, was detected in comparisons between those who received an audiotape (T2 and T3) and those that did not (C and T1); nor did the audiotaping process show any effects (C versus T1). There was no difference in mood state or quality of life between the two groups (T3 versus T2) that received the audiotape (test of the cognitive dissonance hypothesis).

Patients’ decisional role selections were entered as predictors of outcome at 12 weeks post consultation for those patients who listened to the consultation audiotape. Decisional control was significantly associated with follow up mood states and quality of life. With respect to mood state, patients who preferred to share treatment decision-making responsibility with their oncologists had significantly less anger, more vigor, and higher POMS positive score at 12 weeks post consultation than did patients who preferred a more passive role. Patients who indicated that they had assumed an active role during the consultation reported significantly less depression at 12 weeks post consultation than did patients who said they had played a passive role. With respect to quality of life, patients who expressed, before their primary consultation, a preference for collaboration as opposed to passivity in decision making had significantly higher functional and emotional quality of life scores, better overall quality of life, and better breast-cancer specific quality of life at 12 weeks post consultation. Scores on the physical subscale of the FACT were significantly better at 12 weeks post consultation for patients who indicated after the consultation that they had assumed an active or collaborative role.

Hack 2007a

A comparison of the two groups who received a copy of the audiotape (assigned tape; chose tape) with the two groups who did not receive the audiotape (assigned to not receive tape; standard care control) revealed no significant differences at 12 weeks post-consultation in mood state or quality of life. An examination of the impact of the audio-taping process (standard care control vs. assigned to not receive tape) also produced no statistically significant differences. The final comparison showed no significant difference between the two groups (choice vs. assigned) that received the audiotape with respect to mood state or quality of life.
The regression analysis showed a significant association between decisional control and quality of life at 12 weeks post-consultation, but no association with follow-up mood state. With respect to quality of life, patients who expressed, prior to their primary consultation, a preference for active involvement in decision making as opposed to passivity had significantly lower emotional quality of life scores at 12 weeks post-consultation. Preference for the collaborative role prior to the consultation, and indication of active involvement post-consultation were associated with significantly higher overall quality of life and significantly fewer prostate-cancer specific concerns at follow-up, respectively, in comparison to patients who endorsed the passive role.

Analysis 9.1. Comparison 9 Consultation tape in addition to written recommendations versus written recommendations only, Outcome 1 Information recall.

### Information recall

| Study       | Patients who received the audiocassette in addition to the customary written recommendations scored the test on information significantly better (88%, SD 8.7) than those who did not receive the cassette (80%, SD 15.5) in addition to the written recommendations (P = 0.02).  
|            | The subgroup of blinded test questions regarding medications was significantly better for patients who received the cassette (87% v.77%, P = 0.047).  
|            | There were no significant differences in the global rating regarding understanding and remembering recommendations |

Analysis 9.2. Comparison 9 Consultation tape in addition to written recommendations versus written recommendations only, Outcome 2 Use and opinions of intervention.

### Use and opinions of intervention

| Study       | Overall, patients listened to the tape a median of 2 (quartiles 1 to 4) times, whereas family members/friends listened to the cassette a median of 1 (quartiles 1 to 3) times. In 3 cases the patient (11%) and in 8 cases the patient’s family members/friends (29%) reported not having used the cassette at all.  
|            | There was no significant correlation between the number of times the cassette was used and global satisfaction or scoring on the knowledge test. There was a significant correlation between the number of times the cassette was used by a patient and the patients’ global rating of their ability to understand and remember the discussion (r = 0.06, P = 0.0009) as well as their ability to discuss their illness with relatives/friends not at the clinic (r = 0.420, P = 0.03).  
|            | A significant correlation between the number of times the family listened to the cassette and 1) the patients rating of their ability to discuss their illness with family/friends (r=0.5497, P = 0.0098); 2) the patient’s rating of the effectiveness of the cassette in enabling their family to understand and remember the instruction from the consultation (r=0.457, P = 0.02) was observed |
Analysis 9.3. Comparison 9 Consultation tape in addition to written recommendations versus written recommendations only, Outcome 3 Satisfaction with consultation.

Satisfaction with consultation

| Study      | Patients who received the audiocassette in addition to the customary written recommendations found the clinic significantly more useful (8.7 (1.7) versus 7.7 (2.0); P = 0.04) than those who did not receive the cassette in addition to the written recommendations |

Analysis 10.1. Comparison 10 Consultation tape followed by summary letter versus summary letter followed by consultation tape, Outcome 1 Information recall.

Information recall

| Study      | Receiving a tape or letter did not differentially affect information recall scores |

Analysis 10.2. Comparison 10 Consultation tape followed by summary letter versus summary letter followed by consultation tape, Outcome 2 Use and opinions of intervention.

Use and opinions of intervention

| Study      | Both groups used the first intervention more than the second, but this effect was more marked if the letter was received first. (t72 = 6.1; P < 0.0001). |

1/182 (0.5%) patient did not listen to the tape and 5/182 (2.7%) did not read the letter. 1/182 (0.5%) patient did not use either the tape or the letter. These 7 patients were characterised by high levels of anxiety before the consultation and at follow-up (mean scores 9 and 8 respectively).

109/182 (60%) of patients gave the tape to relatives, 17/182 (9.3%) to friends, and 9/182 (5%) to their doctors during the follow-up period (approximately 4 weeks). 66/182 (36.3%) participants did not show the tape to anyone. This pattern was similar for letters and was not affected by the order in which the communication aids were received.

19/182 (10.4%) patients did not share either the tape or the letter, 41/182 (22.5%) shared the letter but not the tape, and 20/182 (11%) shared the tape but not the letter.

Patients who received the letter first read it less often if they rated the letter as containing bad news versus good news (x = 2.8 versus 3.8, respectively; P < 0.01), and if their prognosis as estimated by the medical oncologist was in weeks or months versus years (x = 2.7 versus 3.7; P < 0.05). The emotional impact of the consultation (good-bad news) and prognosis did not affect tape usage, or letter usage if the letter was received second. Sex, age, status, type of cancer, and inpatient/outpatient status did not influence aid usage.

At the second telephone interview, patients ranked six methods of communication after a consultation, including the tape and summary letter they had received and four other possible options (a phone call with a medical oncologist, a letter from the medical oncologist to their doctor, a personal talk with the oncology nurse specialist, or a phone call with a psychologist).
Use and opinions of intervention (Continued)

149/182 (82%) ranked the tape as the first option, versus 69/182 (38%) for the letter (chi-square = 16.5; P < 0.001). Telephone calls from the oncologist or the oncology nurse (present at the consultation) were less popular (2% and 2% respectively). Nevertheless, 37/182 (20.3%) patients ranked interventions they had not received ahead of the consultation tape or letter.

Analysis 10.3. Comparison 10 Consultation tape followed by summary letter versus summary letter followed by consultation tape, Outcome 3 Satisfaction.

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tattersall 1994</td>
<td>The only significant difference between the tape and the letter was that patients felt that the tape was more effective than the letter for reminding them of what the doctor had said (t141 = -1.97; P &lt; 0.05). The worse they considered the news, the less they liked receiving a reminder of the consultation. Types of cancer did not influence total satisfaction scores. However, patients with gynaecologic cancer were less satisfied that the letter helped understanding and recall than those with other cancers (62% v 89%; F2,121 = 4.4; P &lt; 0.01). Similarly, patients with gynecologic cancer felt the letter was less useful (77%) than did other patients (92%; F2,121 = 7.5; P &lt; 0.001). Information preferences influenced satisfaction with the letter. Those who wanted minimal news were less satisfied with the letter than those who wanted good or all news (F2,149 = 9.5; P &lt; 0.001). Patients who wanted non-involvement in decision-making found the tape less useful (F1,147 = 14.4; P &lt; 0.001). Marital status influenced satisfaction with the tape, but not the letter. Single patients liked the tape less than others who were married, divorced or widowed (F3,116 = 4.1; P &lt; 0.01). Those with someone present at the consultation were more satisfied with the tape than those who were alone (F1,134 = 4.979; P &lt; 0.05). Types of cancer did not influence total satisfaction scores. However, patients with gynaecologic cancer were less satisfied that the letter helped understanding and recall than those with other cancers (62% v 89%; F2,121 = 4.4; P &lt; 0.01). Similarly, patients with gynecologic cancer felt the letter was less useful (77%) than did other patients (92%; F2,121 = 7.5; P &lt; 0.001).</td>
</tr>
</tbody>
</table>

Analysis 10.4. Comparison 10 Consultation tape followed by summary letter versus summary letter followed by consultation tape, Outcome 4 Psychological adjustment.

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tattersall 1994</td>
<td>Receiving a tape or letter did not differentially affect anxiety and depression scores. Anxiety scores reduced significantly for both groups over the three assessments.</td>
</tr>
</tbody>
</table>
Appendix 1. MEDLINE (Ovid) search strategy

1. audio$.tw.
2. tape recording/
3. (tape$ or taping).tw.
4. exp video recording/
5. (recording$ or video$).tw.
6. (patient summary or patient summaries).tw.
7. (written or letter$).tw.
8. or/1-7
9. (cancer$ or sarcoma$ or neoplasm$ or oncolog$ or malignant$ or carcinoma$ or lymphoma$ or melanoma$ or tumor$ or tumour$ or leukemia$ or leukaemia$).tw.
10. exp neoplasms/
11. (radiotherapy or chemotherapy or surgery or surgical).tw.
12. or/9-11
13. (consultation$ or interview$ or bad news or discuss$ or advise$ or disclos$ or visit$ or communicat$ or inform$).tw.
14. truth disclosure/
15. office visits/ or “referral and consultation”/
16. or/13-15
17. 8 and 12 and 16
18. Patient Education/
19. consumer participation/ or patient participation/
20. ((patient$ or consumer$ or family or parent$ or sibling$) adj3 (educat$ or participat$)).tw.
21. or/18-20
22. 8 and 12 and 21
23. 17 or 22
24. randomized controlled trial.pt.
25. controlled clinical trial.pt.
26. randomized controlled trials.sh.
27. random allocation.sh.
28. double blind method.sh.
29. single blind method.sh.
30. or/24-29
31. animals/ not (human/ and animals/)
32. 30 not 31
33. clinical trial.pt.
34. exp clinical trials/
35. (clin$ adj23 trial$).ti,ab.
36. ((singl$ or doubl$ or trebl$ or tripl$) adj25 (blind$ or mask$)).ti,ab.
37. placebos.sh.
38. placebo$.ti,ab.
39. random$.ti,ab.
40. research design.sh.
41. or/33-40
42. 41 not 31
43. 32 or 42
44. 23 and 43
45. limit 44 to yr=2005-2007
### WHAT'S NEW

Last assessed as up-to-date: 27 March 2007.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 May 2008</td>
<td>New citation required but conclusions have not changed</td>
<td>This review was originally prepared (1999) and updated (2003) by a team led by Dr. J Tim Scott (see Other published versions of this review). Marie Pitkethly and Steve MacGillivray prepared the latest update of this review (2007-08) with assistance from the Cochrane Consumers and Communication Review Group's editorial base (Rebecca Ryan). The review's authorship has been amended to reflect this.</td>
</tr>
<tr>
<td>5 May 2008</td>
<td>Amended</td>
<td>Converted to new review format.</td>
</tr>
<tr>
<td>31 March 2008</td>
<td>New search has been performed</td>
<td>From the updated searches conducted in April 2005 and May 2007, we identified 4 new studies for inclusion (Hack 2003; Hack 2007a; Hack 2007b; Stephens 2007), bringing the total number of included studies to 16. The inclusion of four new studies did not change the overall findings of the previously updated review.</td>
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</tbody>
</table>

### HISTORY

Protocol first published: Issue 2, 1999

Review first published: Issue 4, 1999

<table>
<thead>
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<th>Date</th>
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<th>Description</th>
</tr>
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<tbody>
<tr>
<td>13 February 2003</td>
<td>New search has been performed</td>
<td>The updated review was published on issue 2 2003 of The Cochrane Library, with four new studies included (bringing the total number of included studies to 12) and a new citation (amended authorship; see Scott 2003 in reference list)</td>
</tr>
</tbody>
</table>
CONTRIBUTIONS OF AUTHORS

For the 1999 review:

V Entwistle (VAE), A Sowdon (AJS), JT Scott (JTS) and I Watt (IW) contributed to the preparation of the protocol and the final manuscript and assessed the relevance and methodological quality of retrieved reports. JTS prepared the first drafts of the protocol and the paper, assessed the studies for inclusion and collected data from the selected studies. VAE, AJS and IW co-assessed the studies for inclusion and checked the collected data against the original reports.

For the 2003 review update:

M Harmson (MH) ran the search strategies; MH and M Prictor (MP) assessed the retrieved studies for relevance and inclusion. MH collected data from the selected studies, MP checked the collected data against the original reports. MH and MP revised the 1999 review text, JTS and VAE approved the revised review.

For the 2007-08 review update:

M Pitkethly ran the search strategies; S MacGillivray (SM) and M Pitkethly assessed the retrieved studies for relevance and inclusion. M Pitkethly collected data from the selected studies which were then checked against the original reports by SM. M Pitkethly and SM revised the 2003 review text. Rebecca Ryan (RR) conducted a further check of the data extraction and methodological quality assessment against the original reports.

DECLARATIONS OF INTEREST

None known

SOURCES OF SUPPORT

Internal sources

- Cochrane Consumers and Communication Review Group, Australian Institute for Primary Care, La Trobe University, Australia.

External sources

- No sources of support supplied

INDEX TERMS

Medical Subject Headings (MeSH)

*Medical Records; *Neoplasms; *Tape Recording; Controlled Clinical Trials as Topic; Mental Recall; Office Visits

MeSH check words

Adult; Humans