CE

Educational Program

The Nurse's Role in Educating Postmastectomy Breast Cancer Patients

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"You have breast cancer" may be some of the most devastating words a woman may hear. Breast cancer is the most common cancer among women and the second leading cause of cancer death in women behind lung cancer in the United States (American Cancer Society [ACS], 2008). According to ACS, more than 180,000 U.S. women will be diagnosed with breast cancer in 2008 and more than 40,000 will die from this disease. Although the incidence of breast cancer has increased, death rates are on the decline due to early detection and improved treatments (ACS, 2008).

The phrase "you have breast cancer" includes the most devastating words a woman can imagine hearing. According to the American Cancer Society (ACS, 2008a), the incidence of breast cancer has increased steadily in the United States over the past several decades and is the second leading cause of cancer mortality in women, exceeded only by lung cancer. The ACS asserts that 182,460 new cases of invasive breast cancer will be diagnosed in U.S. women and 40,480 women will die from breast cancer in the United States in 2008. The good news is that death rates have declined significantly since 1990 because of early detection through screening, increased awareness, and improvements in treatment. Currently there are approximately 2.5 million breast cancer survivors in the United States (ACS, 2008a,b).

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The diagnosis of breast cancer is challenging emotionally and physically; thus, care of the breast cancer patient must encompass more than just the physical needs, and it is essential that you support the emotional dimension with thorough and compassionate education for informed decision making. There must be sensitivity to the cultural, socioeconomic, and religious beliefs of each woman. It is normal for women to have trouble coping with the diagnosis of breast cancer; there are feelings of anger, fear, denial, frustration, and loss of control, changes in body image, sexuality, and mortality. Struggling to understand the various treatment options can be overwhelming for women; the RN is integral in guiding these women through the decision-making process and helping them receive the best treatment for them through informed decision making.

Many private plastic surgery practices throughout the country that care for the reconstructive surgical needs of women with breast cancer often do not have the requisite resources available to meet these needs. In addition, there is still a considerable lack of information, education, services, and support for women with breast cancer. The goal of this paper is to address some of these deficiencies in hopes of augmenting the knowledge of physicians and nurses working with this group of patients. In creatively employing educational information that helps translate the numerous scientific (often confusing) principles and options into an understandable language for patients while promoting an individualized plan for each patient's unique needs, nurses can begin advocating for these women and helping them make informed, educated decisions. Learning styles, learning objectives for the nurse

and patient as well as educational tools will be provided in hopes that nurses will develop programs to support and instruct patients through the decision-making process of breast cancer therapies.

WHERE DO YOU BEGIN?

No one should have to face breast cancer alone, nor should they make uninformed decisions about the care and treatment they receive. The rationale for developing this educational program is to support, educate, and communicate necessary information to women with a diagnosis of breast cancer so they can make rational, informed decisions related to their disease and body-image changes. It is the intent to create open, honest, and individualized information that is appropriate and culturally sensitive to assist nurses in their care of women during their stressful, yet critical, and difficult critical decision-making process while supporting their emotional needs.

Education is a powerful tool, and when patients are armed with information that can be digested and comprehended, women are empowered to obtain the care they want.

RN TO PATIENT EDUCATIONAL PROCESS

What is the RN's role in the patient's educational process? Why is it important? The RN will work intimately with these women from the initial consultation through the recovery phase: assessing, planning, intervening, teaching, supporting, and advocating for these women. As an RN and the patient's advocate, it is imperative to educate yourself in all aspects of care related to this challenging disease and its effect on women. The RN must have an understanding of stress and its effect on learning and informed decision making. RNs must educate themselves on learning styles and theories to best meet the educational needs of the breast cancer patients.

The nurse and healthcare team must consider a number of factors before interfacing with and educating patients during the decision-making process for breast reconstruction following mastectomy. There are various types of breast reconstruction: reconstruction with implants; autologous tissue using muscle, fat, and skin; free tissue transfer, or a combination. Other considerations are related to timing: immediate reconstruction or delayed reconstruction, and type of medical treatments: chemotherapy and radiation. The decision regarding type of reconstruction will include patient preference, body habitus, co-morbidities, smoking history, radiation therapy, age, cost, insurance mandates, community, and familial support and medical expertise.

There must be a thorough and dedicated evaluation of the patient and a strong collaboration between members of the patient's breast cancer team (oncologists, radiologists, general surgeon, reconstructive surgeon, therapists, and nurses). Bringing a partner or friend to each appointment is important as well.

While breast reconstruction will not change the probability of recurrence or mortality and some consider it to be an "optional" procedure, it can have a profound impact on the quality of life for many patients (National Comprehensive Cancer Network, 2008).

LEARNING THEORIES

Instructional design (ID) is the systematic process of translating general principles of learning and instruction into plans for teaching and development of educational materials (Siemens, 2002; Kizlik, 2005). The learning process can be challenging for emotionally charged patients, and it is nearly impossible to provide an entirely automated model for use with all patients. Each patient and support system is unique. They should be evaluated on their individual needs. However, the ID or educational format for breast cancer intervention is an activity set up by the nurse as the educator of the patient and encourages learning from the learner (patient). What this RN educator has found works best is providing one-to-one instruction where the RN sits down with the patient and her support system, introducing the information in a quiet, relaxed environment. The information should be presented verbally and in written format. Internet resources (patient appropriate) should also be provided. Each patient and support person(s) should have the opportunity to ask questions in an unhurried manner; they should continually be assessed for comprehension and emotional stability. Most patients will require more than one face-to-face encounter with the RN and/or via telephone, and the RN should encourage the significant other to accompany the patient to each visit to reinforce and confirm the detailed information as well as provide necessary emotional support in this time of crisis (Cantor, 1992).

Malcolm Knowles, a leader in adult educational theory, established that adult learning occurs best when it follows certain principles:

- 20% of what they **hear;**
- 30% of what they **see;**
- 50% of what they **see** and **hear;**
- 70% of what they **see, hear,** and **say; and**
- 90% of what they **see, hear, say,** and **do.** (National Cancer Institute, 2005)

An understanding of learning theories is an essential component in preparing the educational program, as they are important in the development

of the teaching models used. There are many learning theories available to assist in the learning process based on the needs and ability of the learner; the RN educator must have an understanding of the strengths and weaknesses of each learning theory when designing an educational program for each woman. These theories help illuminate the various ID possibilities for presentation of information for meaningful outcomes.

CONSTRUCTIVISM THEORY

Constructivism is a philosophy of learning founded on the premise that, by reflecting on our experiences, one constructs their own understanding of the world. Individuals generate a set of "rules" and "mental models," which are then used to make sense of their experiences. "Learning, therefore, is simply the process of adjusting our mental models to accommodate new experiences" (Constructivism, 2001). Constructivism focuses on preparing the patient learner to problem solve in difficult and ambiguous situations such as breast cancer treatment.

Experts on the constructive learning hypothesis, Ertmer and Newby (1993), recommend this theory for tasks demanding high levels of processing and personal selection. Using this theory with breast cancer patients is appropriate as women must digest a great deal of complex information and interpret multiple realities in a very short period and under a great deal of emotional stress. When assistance is given to the patient learner to problem solve, they are better able to assimilate their existing knowledge to a unique and stressful situation (Mergel, 1998). The disadvantage of the constructivism theory is that the learners' thinking and experience may actually impede the task.

BEHAVIORAL THEORY

According to the behaviorists, *learning* can be defined as "the relatively permanent change in behavior brought about as a result of experience or practice (Skinner, 1954; Watson, 1913)."

The behavioral-learning theory is represented as a stimulus (S) response (R) with patient or learner treated as a "black box," we only know what is going on inside the box by the patient's overt behavior (Figure 1).

The behaviorists' approach to teaching typically entails the following:

1. Breaking down the skills and information to be learned into small components.
2. Reviewing the learner's work and responses regularly and providing feedback, more information, encouragement, and reinforcement.
3. Behaviorists generally believe that learners can be taught best when the focus is straightforward and focused on the content.
4. This is direct or "teacher-centered" instruction. Lectures, tutorials, drills, demonstrations, and other forms of the teacher controlling the teaching.

Figure 1. Behavioral learning theory.

COGNITIVISM THEORY

Cognitivists use the metaphor of the mind as a computer: information comes in, is processed, and leads to certain outcomes. The cognitivist paradigm thinks of the learner's mind as a "black box" that should be opened and understood. Furthermore, people are not "programmed animals" who merely respond to their environment, but they are rational beings who require active participation to learn, and whose responses are a consequence of thinking.

Cognitive theorists recognize that much learning involves associations established through continuously connecting pieces of information and repetition and reinforcement (Good & Brophy, 1990, p. 187).

COMPARISON OF LEARNING THEORIES

Behaviorism is based on observable changes in behavior and focuses on creating a new behavioral pattern through repetition until it becomes automatic. Cognitivism is based on the thought process behind the behavior where changes in behavior are observed and used as indicators as to what is happening inside the learner's mind. Finally, constructivism is based on the premise that people construct their own perspective of the world, through individual experiences and schema. Constructivism focuses on preparing the learner to problem solve in ambiguous situations (Schuman, 1996).

In an article written by Ertmer and Newby (1993), seven questions emerged to distinguish these three learning theories from one another:

- How does learning occur?
- What factors influence learning?
- What is the role of memory?
- How does transfer occur?
- What types of learning are best explained by the theory?
    - For the teacher (RN)
- What basic assumptions and principles of these theories are relevant to the ID for the particular patient?
- How should teaching be structured to facilitate learning and understanding? (Ertmer & Newby, 1993; Figure 2).

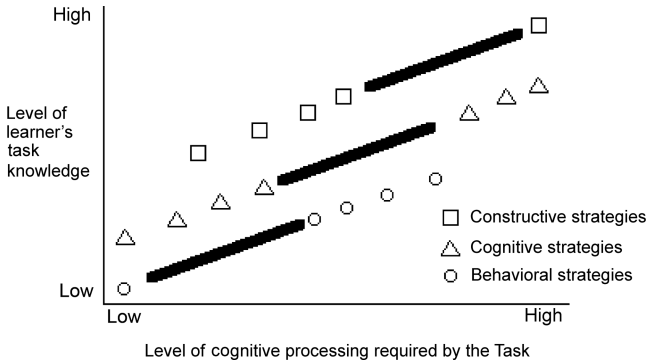

Figure 2. Comparison of associated instructional strategies of the behavioral, cognitive, and constructivist viewpoints based on the learner's level of task knowledge and the level of cognitive processing required by the task. From "Behaviorism, Cognitivism, Constructivism: Comparing Critical Features From an Instructional Design Perspective," by P. A. Ertmer and T. J. Newby, 1993, *Performance Improvement Quarterly, 6*(4), pp. 50–70. Retrieved February 5, 2005, from http://www.usask.ca/education/coursework/802papers/mergel/brenda.htm#Is%20There%20One%20Best%20Learning%20Theo

Informed medical decision making shared with the patient is more likely to result in greater patient satisfaction and cooperation. "Patients are more likely to be satisfied with the outcome of their treatment because they are invested in the decision making process; they are better informed about the options. And the option chosen is more likely to suit their values and lifestyle" (Steinberger, 2003).

EDUCATIONAL OBJECTIVES FOR THE EDUCATOR (RN)

Although breast reconstruction can have a positive effect on a woman's self-image and overall quality of life, only a small percentage of woman actually go on to have this procedure. This RN presumes the reason to be attributable to inadequate knowledge, misinformation, and lack of communication and education of patients and referring physicians. Again, the importance of self (RN)-education related to breast cancer care is imperative for quality patient care in this population.

1. RN will educate her/himself on breast cancer types, stages, and treatments.
   a. Suggested resources:
      i. The ACS http://www.cancer.org/docroot/PAR/Content/PAR_2_3_Breast_Cancer_Resources.asp
      ii. The National Cancer Institute: http://www.cancer.gov/
      iii. The American Society of Plastic and Reconstructive Surgeons: http://www.plasticsurgery.org
      iv. Breast reconstruction options after mastectomy: a consumer's guide http://www.med.umich.edu/surgery/plastic/clinical/breast/breastreconbooklet.pdf
2. Know the resources available in your region.
   a. Cancer centers.
   b. Breast nurse navigators.
3. The RN will utilize the nursing process (American Nurses Association, 2008) in educating the breast cancer patient.
   a. Assess patient demographics and learning styles.
   b. Develop plan for teaching.
   c. Effectively provide written and verbal information to patient and significant other.
   d. Provide Internet materials as appropriate.
   e. Develop an evaluation tool.
4. RN will develop teaching tool(s) to meet the general needs of the breast cancer patient population.
   a. Teaching/ID strategies.
   b. Teaching methods.
   c. Teaching techniques.
5. Set up a network of other RNs in private practices or academic centers in general practice, women's healthcare, gynecology, general surgery, oncology, radiology, pharmacology, acute care, and ambulatory care centers, psychologists, wellness centers, pharmacology/pharmacies, alternative and complimentary groups, and support groups such as the Susan B. Komen Foundation.

EDUCATIONAL OBJECTIVES FOR THE LEARNER (PATIENT)

The goals for the learner (patient) must be developed collaboratively with the RN in this educational effort with the intent being to increase awareness of the breast cancer disease process, medical treatments, and reconstructive options available. This will hopefully lead to an informed decision most beneficial and unique to each woman's emotional, physical, cultural, spiritual, and socioeconomic spheres. It is also the intent of this endeavor to provide a network of professionals where questions can be asked and answered so the goal of greater patient satisfaction can be achieved. As "high anxiety can make learning nearly impossible" (Bastable, 2003, p. 297), it is imperative to provide these patient learners a safe, nurturing environment sensitive to emotions, body changes, culture, and psychosocial concerns.

1. The patient will be able to communicate feelings related to diagnosis, treatment options, and body changes.

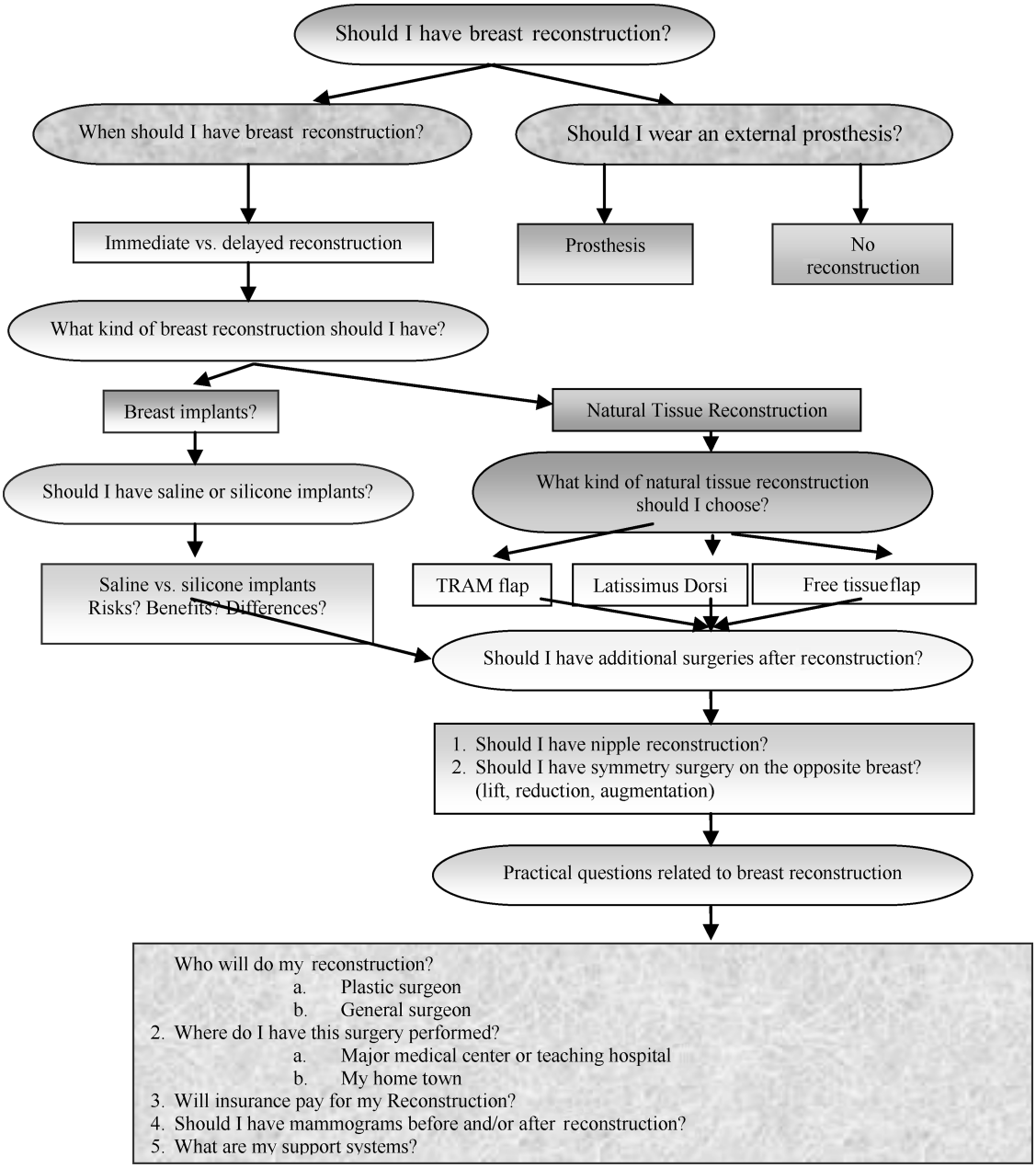

Figure 3. Women considering breast reconstruction postmastectomy.

2. Discuss various options for tumor removal and what these will mean medically, physically, and emotionally.
3. Gain thorough, accurate, easy-to-understand information on breast reconstruction options.
4. Describe the reconstructive surgery options and what they will entail.
   a. Delayed versus immediate reconstruction.
   b. Implants versus tissue-transfer techniques.
   c. Risks and benefits of surgery.
5. To facilitate satisfactory decision making for treatments with the plastic surgeon.
6. To gain confidence in the plastic and reconstructive surgery staff and ancillary healthcare team.
7. Summarize information relevant to the surgical management of breast cancer (Bonaldi, 2000).

INSTRUCTIONAL MATERIALS AND RESOURCES

The instructional materials and resources for use with this patient population must be given face-to-face in a nonthreatening environment and with sufficient time for questions. Patients must be given printed, visual, audiovisual, and Internet information from the ACS, The American Society of Plastic Surgeons, the Susan B. Komen Foundation, and

The Breast Cancer Consumers' Guide among others in conjunction with discussion and constant reinforcement. Increasing data on the Internet provides even greater access to information and allows patients to view these at home. A decision-making tree

TABLE 1 Lesson Plan Format

Objective
Increase awareness of the breast cancer disease process
To allow women the opportunity to make an informed decision on breast reconstruction
Facilitate periodic meetings of the healthcare team (oncologist, general surgeon, rehabilitation, psychology, etc.) to identify ways to enhance and coordinate care
Provide a supportive network where questions can be answered and goals can be achieved for greatest patient satisfaction diagnosis through final stages surgery and medical treatments
Content
Explain the disease process of breast cancer
Explain the procedures of biopsy, breast conservation surgery (lumpectomy, segmental mastectomy), mastectomy, and bilateral mastectomies
Outline the definition of breast reconstruction
List the types of breast reconstruction available, the risks and benefits of each procedure, what is involved surgically, post-operatively and what can be expected for the longterm
Discuss goals of reconstruction
Special considerations of reconstruction (delayed vs. immediate) related to medical care (radiation and/or chemotherapy)
Anesthesia, outpatient vs. inpatient facility
Financial considerations (pre-authorization of insurance, out-of-pocket expense, cost of procedures)
Risks (surgical, smoking, infection, capsular contracture)
What to expect after breast reconstruction (healing, "normalcy," physical appearance, emotions, recurrence, support groups, and systems)
Instructional methods/teaching strategy
Assess patient needs: emotional, physical, mental, psychosocial
Involve patients and family (significant other) in decision-making process
Direct, one-on-one teaching
Provide information on surgical reconstructive options through face-to-face consultation, pamphlets, effective videos, Internet resources and tele-conferences, use of interactive educational software, support-group networks, and oncology team providers
Demonstrate sensitivity to emotional, cultural, and values of each patient
Frame all medical information in layperson's terms to increase understanding for informed decision making
Evaluation method
Provide written evaluations
Listen to patient feedback, questions
Evaluate postconsult office calls to help assess patient and significant others comprehension
Is/has patient been able to make a decision?

TABLE 2 Complete Content Outline

Content outline are the materials patient would be given and shared with them; it is the information the patients will need to make an informed decision for their treatment and reconstructive care

1. Explain the disease process of breast cancer
2. Explain the procedures of biopsy, breast conservation surgery (lumpectomy, segmental mastectomy), mastectomy, bilateral mastectomy
3. Outline the definition and process of breast reconstruction
4. List and provide pictures of the types of breast reconstruction available, the risks and benefits of each procedure, what is involved surgically, pre-operative and post-operative care, and what can be expected in the long term
   a. Implants
   b. Tissue expanders
   c. Autologous tissue reconstruction
      i. TRAM flap (transverse rectus abdominous muscle)
      ii. Free TRAM flap (microsurgical)
5. Discuss goals of reconstruction
   a. Make breasts look symmetric
   b. Regain breast contour
   c. Creation of nipple areola complex
   d. Convenience of not requiring external prosthesis
   e. Physical "normalcy"
6. Special considerations of reconstruction (delayed vs. immediate) related to medical care (chemotherapy, radiation, co-morbidities, smoking)
7. Anesthesia, outpatient vs inpatient or intensive care post-operatively
8. Financial considerations (pre-authorization of insurance, out-of-pocket expense, cost of procedures and implants)
9. Risks
   a. Surgical
   b. Co-morbidities
   c. Smoking
   d. Infection
   e. Fluid collection
   f. Bleeding
   g. Capsular contracture
   h. Scarring
   i. Failure of graft
10. What to expect after breast reconstruction?
    a. Healing time
    b. Drains
    c. Post-operative care
    d. "Normalcy"
    e. Physical appearance
    f. Emotions
    g. Recurrence risk/statistics
    h. Support groups
11. Provide a copy of your decision-making tree
12. Utilize the PowerPoint presentation "Unlocking the Mystery" to help you (contact author for copy)

is often helpful for patients as it graphically displays the options available. Patients should also be encouraged to keep personal diaries to record treatment dates, symptoms, feelings, and questions (Tables 1 and 2).

STRATEGIES FOR EVALUATION OF LEARNING

"The process of evaluation is to gather, summarize, interpret, and use data to determine the extent to which an action was successful" (Bastable, 2003, p. 494). It is relatively easy to measure the patient's progress with direct instruction that is helpful when teaching facts to assist the patients' decision-making process. Evaluation of the educational process is important, especially when the educator is individualizing the care for the women with breast cancer. Outcome evaluation helps determine the effects of the education provided to the patient and measures any changes that occur. Again, breast cancer patients are under a great deal of emotional stress related to morbidity and mortality, body-image change, and having to make life-altering decisions. The evaluation of the information imparted to patients is critical to future successful teaching efforts with other patients.

The nurse as educator must continually assess the patient's understanding, which is achieved through face-to-face interactions and observation of the patient's questions and decision-making process. Evaluation forms can be given to the patient; however, this can increase stress and anxiety and is not always beneficial in discerning patient understanding.

CONCLUSION

The ACS (2008) reveals that each year more than 180,000 women in the United States will face the reality of breast cancer diagnosis. It is incumbent on physicians and nurses to educate these women so they can make informed decisions related to the care they will receive or refuse. With new approaches and technologic advances in reconstructive surgery being made, women have more choices yet they may be encumbered by emotional stress, which limits their ability to think clearly. It is imperative for the RNs and other healthcare team members to provide information, support, be available for questions, and follow up closely with these patients and families so they make informed decisions regarding the treatments they choose. The RNs' role with this patient population is integral to successful patient education and satisfaction; you can dramatically improve awareness, knowledge, and emotional support to these women.

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Every year, *Plastic Surgical Nursing Journal* announces three writing awards, taking into consideration all the feature articles that have appeared in the previous year's issues. We are proud to announce the winners.

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The **Second Place Winners** were Cynthia Figueroa Haas, PhD, APRN-BC, Angela Champion, BSN, RN, and Danielle Secor, BSN, RN, for their article "Motivating Factors for Seeking Cosmetic Surgery: A Synthesis of the Literature," which appeared in the October/December 2008 issue, Volume 28(4), pp. 177–182**.**

The **Third Place Winners** were Joanne Gladfelter, RN, CPSN, and Diane Murphy, MBA, for their article "Breast Augmentation Motivations and Satisfaction: A Prospective Study of More Than 3,000 Silicone Implantations," which appeared in the October/December 2008 issue, Volume 28(4), pp. 170–174.