In the Moment: Women Speak About Surgical Treatment Decision Making Days After a Breast Cancer Diagnosis

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A diagnosis of breast cancer will affect the lives of one of every eight women in the United States (American Cancer Society, 2007), launching them into a stressful period of uncertainty and rapid, life-changing decision making (Hewitt, Herdman, & Holland, 2004). Most women diagnosed with early-stage breast cancer are candidates for the equally efficacious treatments of lumpectomy and radiation or mastectomy with or without reconstructive surgery (Fisher et al., 2002). Studies of women’s surgical treatment decision making have shown that, when offered a choice between these options, women vary in their desired preferences for information and the degree to which they wish to participate in the decision-making process. In general, younger and more educated women desire more information and participation in decision making than older and less educated women (Beaver, Luker, Owens, Leinster, & Degner, 1996; Bilodeau & Degner, 1996; Hawley et al., 2007; Petrisek, Laliberte, Allen, & Mor, 1997; Wallberg et al., 2000), although individual variation among women exists (Degner et al., 1997; Hack, Degner, & Dyck, 1994). These studies also identified that, regardless of age, women often participate in the decision-making process more or less than they desire.

Identifying which women desire more or less involvement in surgical treatment decision making and matching that degree of involvement, although difficult (Hawley et al., 2007), may increase women’s satisfaction and decrease decision regret (Lantz et al., 2005). Active participation, however, regardless of women’s preferences for involvement, also has been found to support better psychosocial outcomes for women (Deadman, Leinster, Owens, Dewey, & Slade, 2001; Hack, Degner, Watson, & Sinha, 2006). Others argue that, regardless of women’s preferences, they may not have adequate knowledge with which to make informed surgical treatment decisions (Fagerlin et al., 2006).

Lack of consensus among previous studies may be in part the result of solicitation of women’s preferences for information and participation in decision making months to years after their decisions had been made. The time that elapsed between women’s diagnoses and data collection in the studies raises questions about the accuracy of their narratives.