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Terminating active cancer treatment – clinical and ethical perspectives

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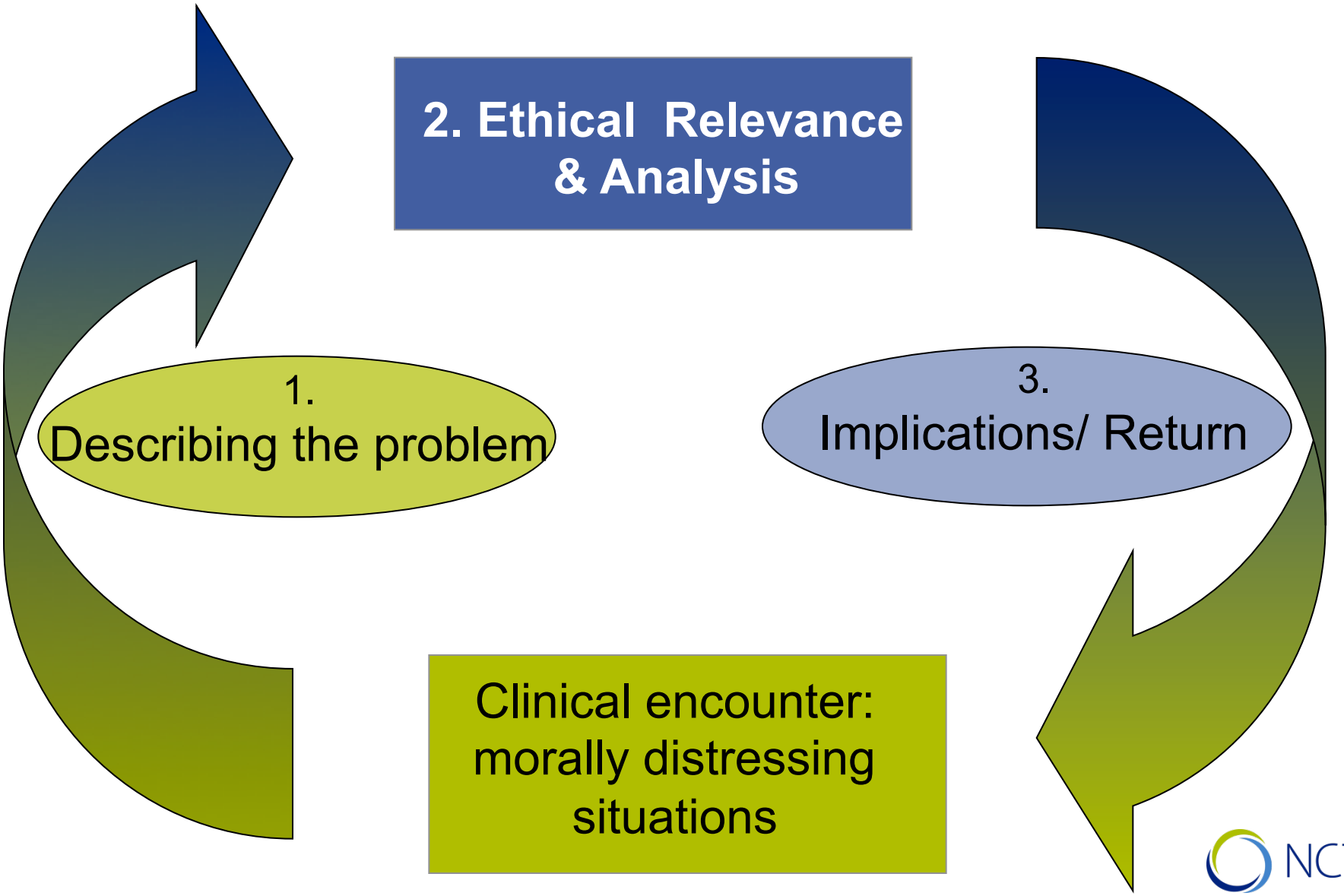
Overview

1. Current practice of decisions to limit treatment (DLT)
2. What situations are perceived as challenging in DLT?
3. Why are they challenging?
4. Implication for ethical and communication approaches

Empirical evidence and ethics of Decisions to limit treatment



Decisions to limit treatment ...

1. **....are common.**

   Half of the non-sudden deaths in Europe are preceeded by a decision against some kind of therapeutic option Bosshard et al Arch Intern Med 2004

2. **. ... are perceived as difficult and prone to causing conflict**

   80% of medical directors of unversity hospital dept identified DLT as the ethically most challenging situation in every day clinical life

   Vollmann et al, Dtsch Med Wochenschr 2004

3. **... are relevant in order to avoid overtreatment at the End-of-Life**

   Timely discussions about DLT enable to forgo chemotherapy in late cancer treatment –> better QoL, longer survival

   Temel NEJM 2011, J Clin Onc 2012

4. **Most Patients want to be involved in these decisions.**

   Bruera et al. JCO 2001

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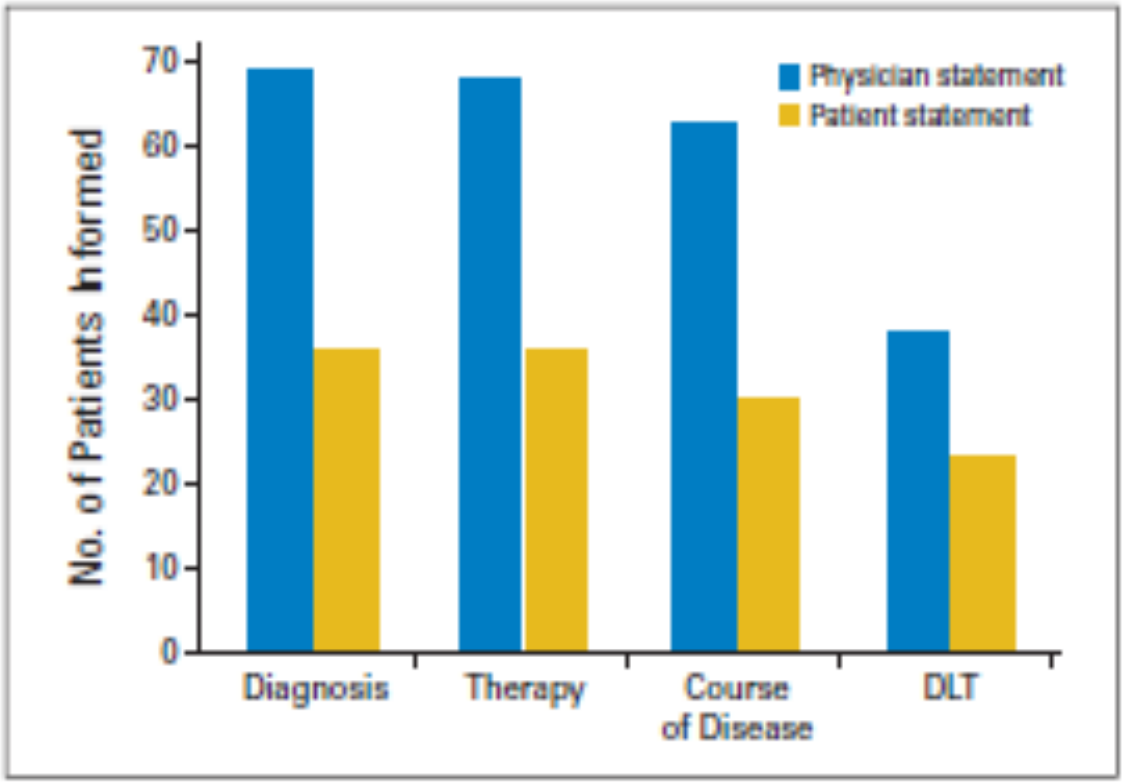
The current practice of decisions to limit treatment

Physicians and patients ‘ statement about having/being informed
About: Diagnosis, therapy, prognosis and DLT

Winkler, EC et al J Clin Onc 2009



1. less than 50% of patients were involved in DLT

2. Main predictor for involvement was agreement with physicians palliative treatment goals

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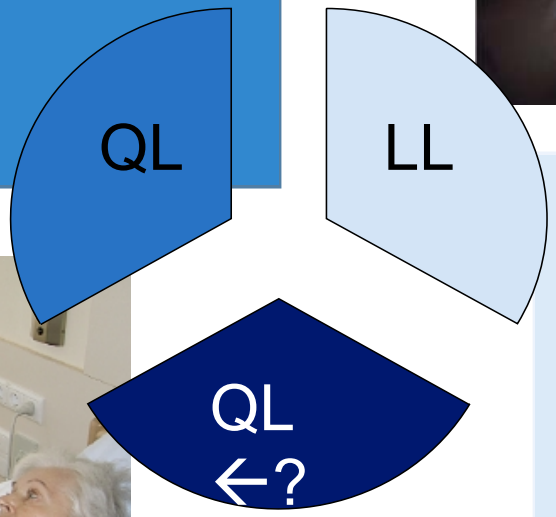
The current practice of decisions to limit treatment

Patient preferences known: 51 Pt

69% Qualtiy of life
75 % involved



31% Length of Life
37% involved

Voogt 2005 J Clin Oncol 23:2012-2019/
Winkler 2009 J Clin Oncol.

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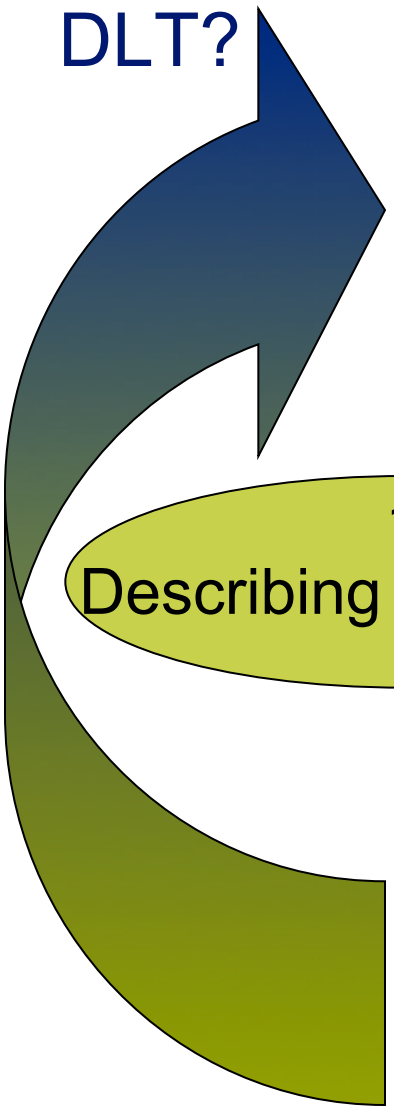
What is challenging and ethically relevant in DLT?



1. Describing the problem

1. Less than half of patients are involved in DLT

2. Especially if their treatment goal differs form the treatment goal of their physicians

3. Most often this is the case, if the patient prefers active treatment

Clinical encounter: morally distressing situations

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Reasons for dissens bw Patiens and Oncologist

A. Patients have a realistic interpretation of the facts, but evaluate benefits and harm differently

B. Preferences are based on unrealistic or insufficient information

- 70-80% of patients incorrectly perceive chemotherapy as curative
- Physicians overestimate survival, avoid to prognosticate or to involve the patient in DLT
- Patients strategy of denial – pts who held false beliefs about treatment effects rated their communication with their physician very favorably

Weeks,NEJM 2012/ Craft, Eur J Can Care 2005 / Schildmann Oncologist

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Study: Patients' treatment and communication preferences in Re DLT

Cohort Study: n = 194 cancer patients (gastrointestinal, urological and bronchial carcinoma)

Age ø 63 years (SD: 10.3; Range: 33-83)
Female 62 (32%) Male 132 (68%)

Endpoints:

1. preferences regarding QL and LL,
2. communication preferences,
3. impact of family members on treatment preference

Winkler et al; ASCO 2014 / Laryionava K Oncol Res Treatment 2014

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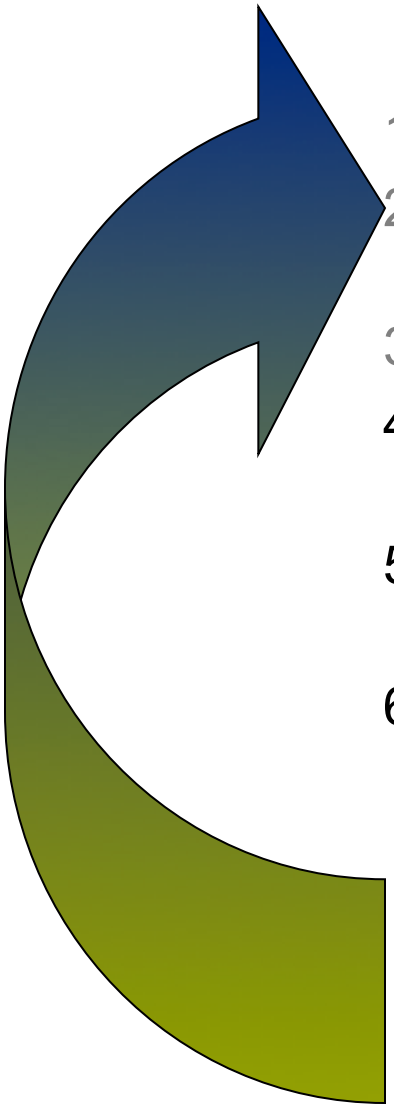
What is challenging and ethically relevant in DLT?



1) Less than half of patients are involved in DLT
2) No involvement, if Pts treatment goal differs form the treatment goal of their physicians
3) Most often this is the case, if patients prefer LL
4) Patients striving for LL did not want their oncologists to discuss treatment limitation with them.
5) Family has an impact and is associated with a preferences for LL
6) the majority of patients preferred their physicians to discuss therapeutic limitations as early as possible. This preference was associated with striving for QL.

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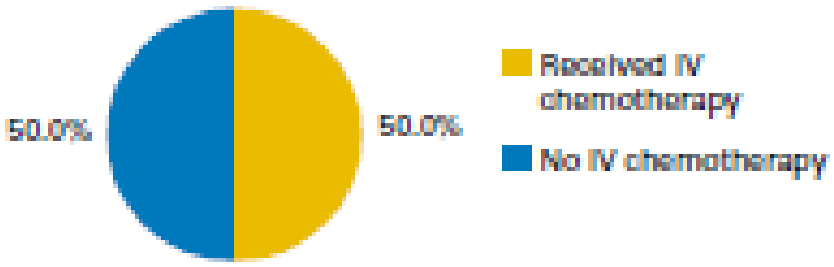
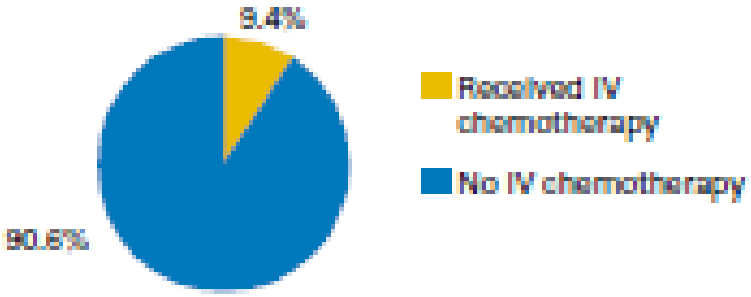
Does patients understanding their prognosis matter?

Impact on aggressiveness of care (Temel Study)

Patients with inaccurate Prognostic understanding



Patients with accurate Prognostic understanding



Temel et al JClinOnc 2011

Repeated early palliative follow up
→improved accurate understanding
→Enabled to forgo chemotherapy
→Enhanced Quality of life
→Prolonged life (8,9 vs 11,6 month median OS)

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How early is „early“?: Oncologists views on timing DLT

Method: Qualitative Interview Study (semistructured): Hem/Onc LMU Munich
22 physicians / 7 nurses Working experience: from 8 months-34 years

Perceived challenges:

1. unrealistic expectations (marke in CCC)
2. Uncertainty about communication
3. Uncertainty about timing

Observed approaches

(1) waiting until patient starts the discussion about forgoing cancer-specific treatment;

(2) waiting until all tumor-specific therapeutic options are exhausted

(3) preparing patients gradually throughout the course of disease (anticipatory approach)

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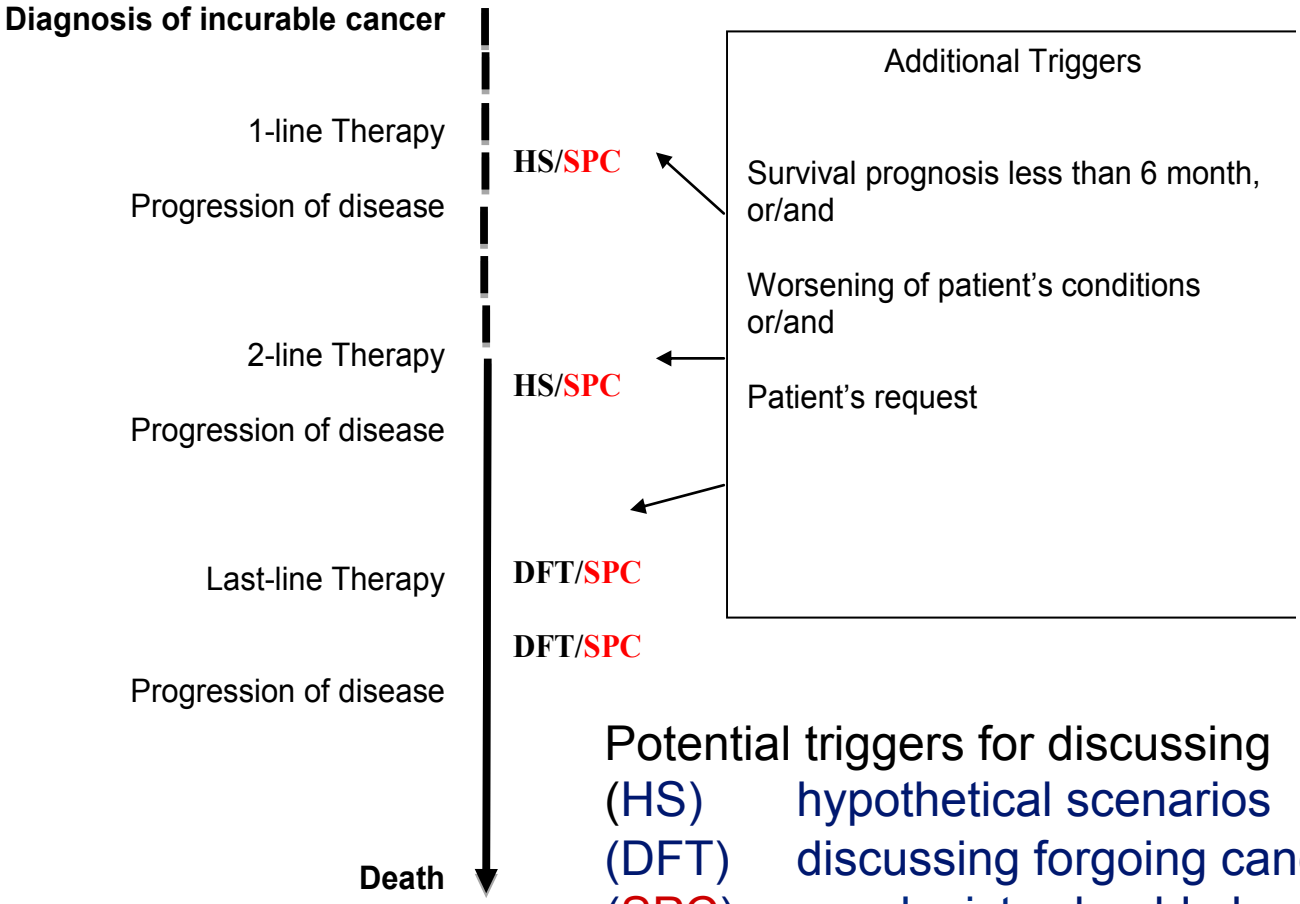
Framework for Timing of the Discussion about Forgoing Cancer-specific Treatment



Potential triggers for discussing
(HS) hypothetical scenarios
(DFT) discussing forgoing cancer-specific treatment
(SPC) oncologists should always consider measures supportive and palliative care

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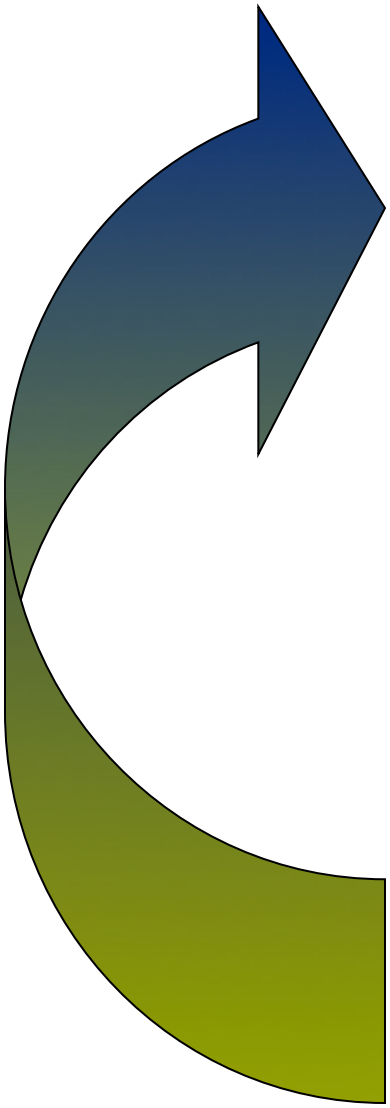
What is challenging in deciding against treatment?



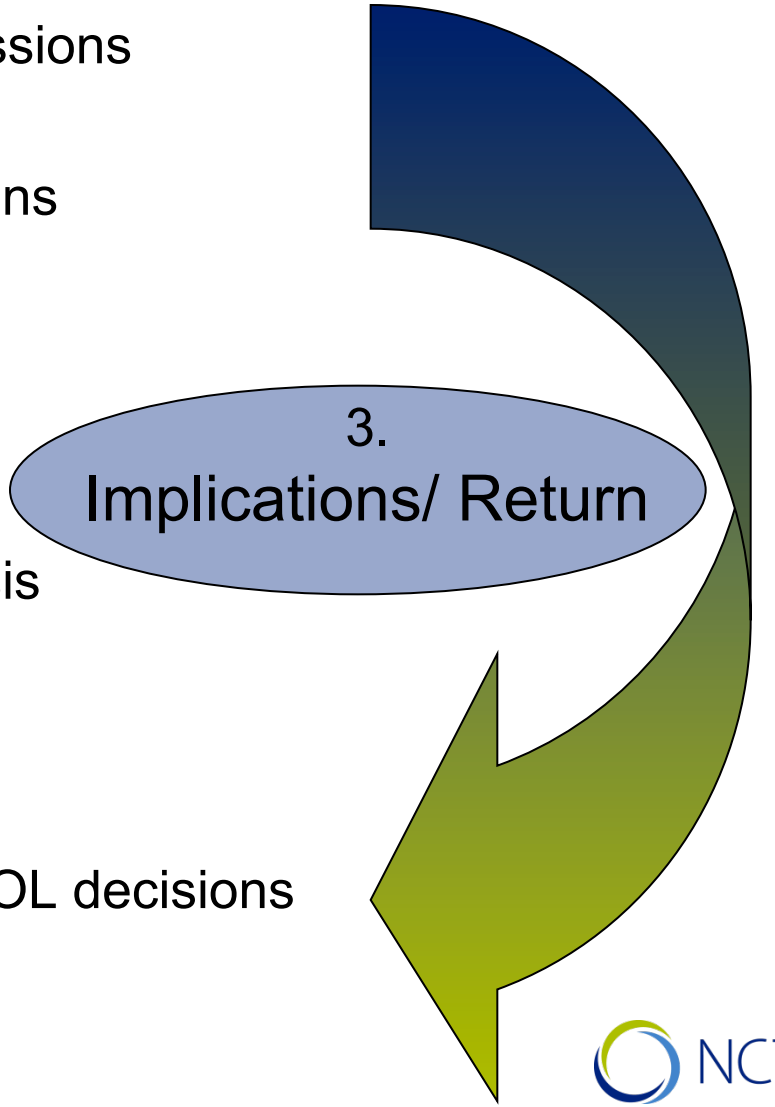
1) To involve patients that are not prepared for EOL decisions

2) To involve the pt family

3) Timing / To prepare patients for these decisions earlier in the disease trajectory

Implications for cancer care

1) Communication training for EOL-discussions
2) Communication with patient care giver
3) Ethical reflection of ones own evaluations



Beyond skills:

2.) Knowledge: about the impact of an accurate understanding of prognosis and timing recommendations

3.) Professional attitude:

→ taking on the responsibility for preparing the patient for EOL decisions

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Thank you for your attention and further questions

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