

ESMO PRECEPTORSHIP PROGRAMME SUPPORTIVE
AND PALLIATIVE CARE

SESSION 3 PREPARE FOR AND CARE DURING EOL

**BALANCING HOPE AND COPING
WITH REALITY IN MODERN
ONCOLOGY: INTEGRATING VALUE-
BASED ADVANCED CARE
PLANNING IN ROUTINE CARE**

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ESMO Designated Centers Working Group, past Chair

Monday 16. April 2018 / 13:25-13:50

Lugano

Truthful information does not reduce hope

**End-of-Life Discussions have a concrete
content**

**Advanced Care planning
Definition, process, tools**

Struggle of professionals to complete Ads

Barriers to complete Ads

Impact of ADs on outcomes

Role of oncologist in ADP

Promises for a «wonderdrug» coupled with the incapacity of oncologists to predict response to (new) anticancer treatments may hinder adequate preparation for end-of-life

Doctors want to give their cancer patients every chance. But are they pushing off hard talks too long?

By BOB TEDESCHI @bobtedeschi
SEPTEMBER 1, 2017

See nice “thinking papers”:

Schilling G, Schulz-Kindermann F. Recent Results Cancer Res 2018;210:181-190

Keeping Expectations in Check with Immune Checkpoint Inhibitors. Temel J et al. JCO 2018; epub



Bernard “Biff” Flanagan, 78, was diagnosed with esophageal cancer in late 2015 and later tried immunotherapy.

SANDY HUFFAKER FOR STAT

Truthful information does NOT reduce hope

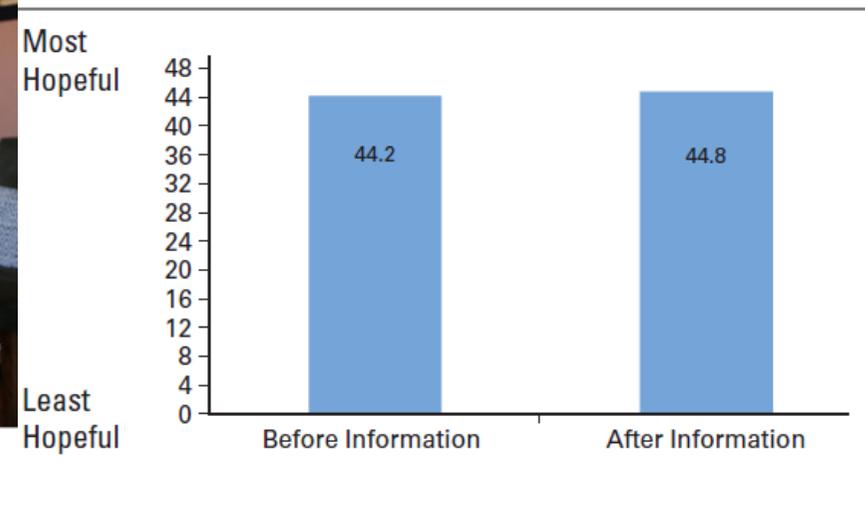


Fig 1. The effect of truthful information on the Herth Hope Index. Hope does not change with honest cancer information about prognosis and options. Data adapted with permission.²

Smith T. Oncology 2010;24:521-5

Communication About Serious Illness Care Goals A Review and Synthesis of Best Practices

Evidence That Early Communication About Goals of Care and End-of-Life Preferences Improves Care

End-of-life conversations are associated with better **quality of life**, reduced use of life-sustaining treatments near death, earlier hospice referrals, and care that is more **consistent with patient preferences**

Patients who received early palliative care showed significant improvements in **quality of life** and mood

Patients who engaged in advance care planning were more likely to have **their wishes known and followed**.

Preparation for the end of life is associated with improved bereavement **outcomes for family**

Bernacki RE & Block SD. JAMA Intern Med 2014; 174:1994-2003

EOL-Communication-intervention is (cost-) effective¹
Systematic review EOL-discussion intervention: evidence²

Existing evidence does **not** support the commonly held belief that **communication about end-of-life issues** increases **patient distress**. However, conversations about care goals are often conducted by physicians who do not **know the patient**, do not routinely address patients' **nonmedical goals**, and often fail to provide patients with sufficient **information about prognosis** to allow appropriate decisions; in addition, they tend to **occur so late** in the patient's illness that their impact on care processes is reduced

1: Zhang B Arch Int Med 2009;169:480-8

2: Walcak A et al. Pat Educ Couns 2016;99:3-16

Communication on serious-illness care goals – EOL-preparation: **ACP**

*«Advance care planning is **not** just concerned with preparing for incapacity, autonomy and exercise of control.*

It involves preparing for death, social processes and personal relationships”

*“How people want to face their own mortality and plan for their end-of-life is a **personal experience** lived within the context of their **lives and relationships**”*

you / me: Cancer Clinician with relationship to patient

Singer PA et al. Arch Intern Med 1998;158: 879–84

Russel S Palliative Medicine 2014;28:997-9

Advanced Care Planning → KEY CONTENTS

Structured ACP («EOL-Discussions») can convey optimism, also the hope to be able to do something oneself (empowerment), and *may* improve OAS

1: Chochinov HM Lancet Oncol
2011;12:753-6 /

Martinez M Palliat Med 2016 Aug 26

2: Portman D J Pain Symptom
Manage 2018; epub

- . Discuss living will, DNR, value-based diagnostic / therapeutic interventions
- . Solve legal and financial issues
- . Support concrete legacy work (dignity therapy¹, narratives, books)
- . Use of remaining life time & finish business: dreams, duties, people; Bucket-list²
- . Support pre-mortal grief work
- . Preferred place of death, funeral
- . Care in dying phase (awakeness, skin care, pastoral care, catheter, etc.)
- . Prepare family for after death roles

Advance Care Planning consensus definition *guide clinical, research, & policy initiatives*

Delphi (10 rounds) of 52 multidisciplinary, international experts, 4 countries (US, CA, NE, AUS)

Tensions concerning ACP concepts

- conversations vs. written advance directives
- patients' values vs. treatment preferences
- current shared decision making vs. future med decisions
- who should be included in process: surrogates, clinicians
- *ACP not equal to actionable medical orders (POLST)*

Definiton: “Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care”.

Goal: “To help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.”

Strategies to support ACP

- Merge entrusted people incl. HCP
- Assess pts readiness, information preference (health, prognosis)
- Assess first what is most important
- Document pts values & choices
- Revise ACP over time (health, life changes), specify future medical tx
- Identify trusted person(s) to decide (Power of Attourney)
- Accessible recorded preferences

Sudore RL et al. JPSM 2017;53:821-32

Advance care planning is a *process* whereby values and goals are sensitively explored and documented to uphold patients' wishes should they become incompetent to make decisions in the future

A skilled facilitator (experienced oncology nurse, with post graduate training in palliative care and many years experience conducting end-of-life conversations with cancer patients) conducted an ACP intervention with stage III/IV cancer patients and invited caregivers. It a 5 step guided Process incorporating the vignette technique and optional completion/integration of ACP documents into electronic medical records

1. Identifying and exploring gaps in knowledge and understanding of ACP
2. Eliciting understanding of the role of ACP in cancer
3. Tailoring the intervention to address unique decision-making needs and preferences
4. Supporting the actualisation of an advance care plan
5. Summarising interview and assessment for additional support

Feasibility shown: recruitment, high comppliance, some distress, less decisional conflict

Michael et al. BMC Palliative Care 2015

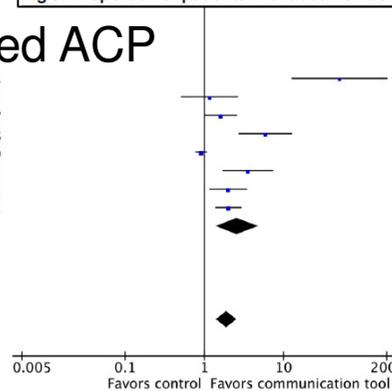
Interventions (Invt)

- verbal discussions alone (n=9)
- paper tools alone (n=9)
- verbal discuss with paper (n=20)
- videos (n=12)
- computer programs (n=4)
- complex multimodal Invt (n=10)
- invt directed @ HCPs not pts (n=3)

Study or Subgroup	Communication tool		Usual care		Weight	Risk Ratio		Year
	Events	Total	Events	Total		M-H, Random, 95% CI	Year	
1.1.1 Low risk of bias studies								
Molloy 2000	444	636	374	656	11.8%	1.22 [1.13, 1.33]	2000	
Grimaldo 2001	63	99	57	99	11.1%	1.11 [0.88, 1.38]	2001	
Heiman 2004	38	360	5	334	5.6%	7.05 [2.81, 17.70]	2004	
Epstein 2013	19	30	15	26	9.5%	1.10 [0.72, 1.68]	2013	
Subtotal (95% CI)		1125	1115	1115	38.0%	1.36 [0.98, 1.88]		
Total events	564		451					
Heterogeneity: Tau ² = 0.07; Chi ² = 16.06, df = 3 (P = 0.001); I ² = 81%								
Test for overall effect: Z = 1.86 (P = 0.06)								
1.1.2 Unclear risk of bias studies								
Rubin 1994	102	552	2	549	3.3%	50.72 [12.58, 204.55]	1994	
Reilly 1995	11	83	9	79	6.2%	1.16 [0.51, 2.66]	1995	
Landry 1997	33	95	20	92	9.1%	1.60 [0.99, 2.57]	1997	
Dexter 1998	45	277	7	253	6.6%	5.87 [2.70, 12.78]	1998	
Brown 1999	190	619	212	628	11.5%	0.91 [0.77, 1.07]	1999	
Perry 2005	22	63	8	81	6.9%	3.54 [1.69, 7.40]	2005	
Morrison 2005	17	43	19	96	8.5%	2.00 [1.16, 3.45]	2005	
Pearlman 2005	57	136	30	144	10.0%	2.01 [1.38, 2.93]	2005	
Subtotal (95% CI)		1868	1922	1922	62.0%	2.61 [1.40, 4.85]		
Total events	477		307					
Heterogeneity: Tau ² = 0.68; Chi ² = 91.09, df = 7 (P < 0.00001); I ² = 92%								
Test for overall effect: Z = 3.02 (P = 0.003)								
Total (95% CI)		2993	3037	3037	100.0%	1.92 [1.43, 2.59]		
Total events	1041		758					
Heterogeneity: Tau ² = 0.19; Chi ² = 107.86, df = 11 (P < 0.00001); I ² = 90%								
Test for overall effect: Z = 4.31 (P < 0.0001)								
Test for subgroup differences: Chi ² = 3.28, df = 1 (P = 0.07), I ² = 69.5%								

Fig 4. Proportion of patients with documented advance care planning.

Documented ACP



Structured communication tools for EOL decision-making: Effect on completion of ACP in adults outpatient care

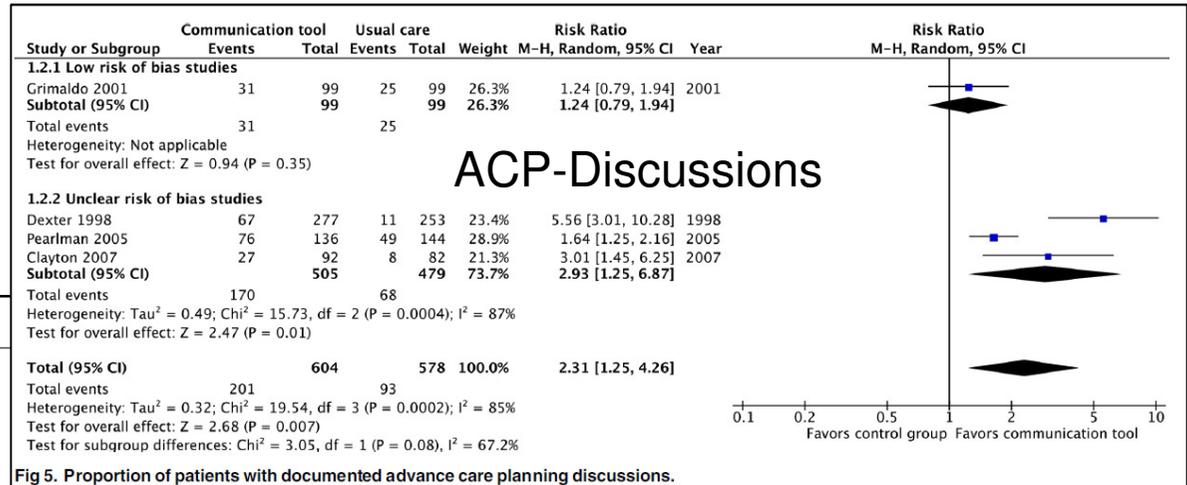


Fig 5. Proportion of patients with documented advance care planning discussions.

In addition to communication skills, communication tools can and shall be used for ACP

Impact of ACP on outcomes: sufficient evidence

Complex ACP interventions (n=20, 2 with cancer patients) may increase the frequency of **out-of-hospital (ooH) & out-of-ICU care** and **increase compliance with patients' EOL wishes**¹

Primary brain tumors (1 RCT, 18 cohorts): **lower hosp readmission rates, ICU utilization**²

1307 pts ≥65y, Taipei, age 84y, 79% AD; life-sust. Tx 2% vs 5%) OddsR **CPR** 0.21; **ventil** 0.32³

2159 pts US, POLST (med 1 mt <†) vs AD (3.3 mt): **ooH death** 86% vs 72%; **hospice** 50% vs 27%⁴

ACP may improve (RCT elderly) **ongoing and EOL care, patients personal satisfaction**, families of pts with ACP have **less anxiety, depression and stress** and **more satisfaction**^{5,6}

ACP in nursing homes can **reduce hospitalizations** (9% - 26%), without increasing mortality⁷

Cost of care: systematic review (4 RCT, 1 pre-post, 2 observation), variable ACP & pt selection
6/7 studies report **reduced costs, but variability in ACP** → training required of HCPs⁸

Pat dies **inpt oncology** (Mayo, n=120), **no** sign impact of AD 38%) on cost (adjusted age, LOS)⁹

1: Brinkman-Stoppelenburg A, et al. Palliat Med 2014;28:1000–25 // 2: Song K et al. Front Oncol 2016;6(223):1-14

3: Yen Y-F et al. JPSM 2017; September // 4: Pedraza S et al. J Oncol Pract 2017; July // 5: Detering KM et al. BMJ 2010;340:1345

// 6: Weathers e et al. Maturitas 2016;91:101–9 // 7: Martin RS et al. J Am Med Dir Assoc 2016;17:284-93

8: Klingler C et al. Palliative Medicine 2016;30:423–33 // 9: Tan TS, Jatoi A. Oncology 2011;80:118–122

What tools do you use in your institution to guide the Advanced Care Planning process?

Patient value assessment

- . Who are you? What do I need to know about you?
- . What values are important in your life?

Advanced directives

- . Medical decisions: Resuscitation Y/N, Intubation, other (nutrition, etc)
- . Surrogate decision maker (and how informed?)

Structured palliative interview

- . Legal, financial issues, support needed (national laws)
- . Discuss place-of-death, professional support during dying phase
- . Include family members, prepare for life after death, grieving before death
- . Actively discuss «bucket-lists», use time

document all in medical chart

Advanced Care Planning → includes AD but goes beyond Values, decision making, family members

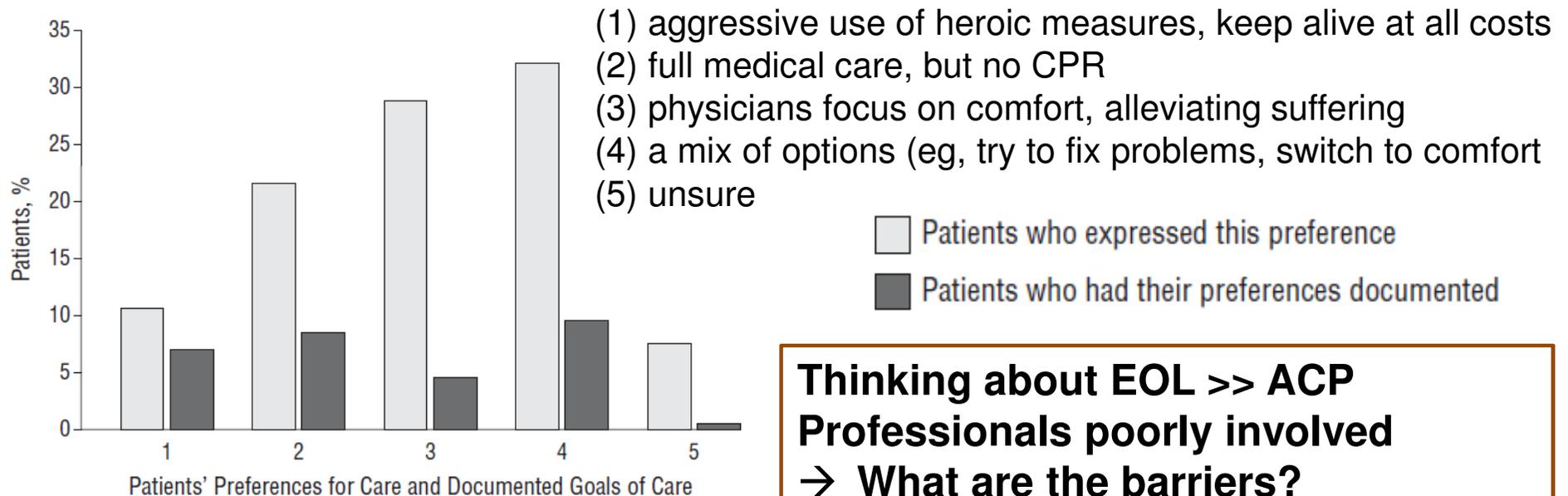
Focus groups (n=5-6±2) of 38 Pts (78y) and 31 Surrogates (57y), mixed race/ ethnicity (Latino, African American, Asian) , stepwise, iterative framework analysis approach, until saturation ¹

- Experiences with **medical decision making** and advice about how best to prepare
- Experiences with **discussions about death** and advice about how best to prepare
- Opinions about **what one should do** if faced with a **serious medical illness** (vignette)

Overarching Themes	All Participants, ^a N= 69	Patients, ^b N= 38	Surrogates, ^b N= 31
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Advance directives are not sufficient	34 (49.3)	11 (29.0)	23 (74.2)
Values clarification	61 (88.4)	35 (92.1)	26 (83.9)
Surrogate decision makers	43 (62.3)	28 (73.7)	27 (87.1)
Leeway in decision making	55 (79.7)	28 (73.7)	27 (87.1)
Informing family/friends of wishes	60 (87.0)	33 (86.8)	27 (87.1)

Advance Care Planning is underused in clinical practice → *insufficient preparation and uptake by Professionals*

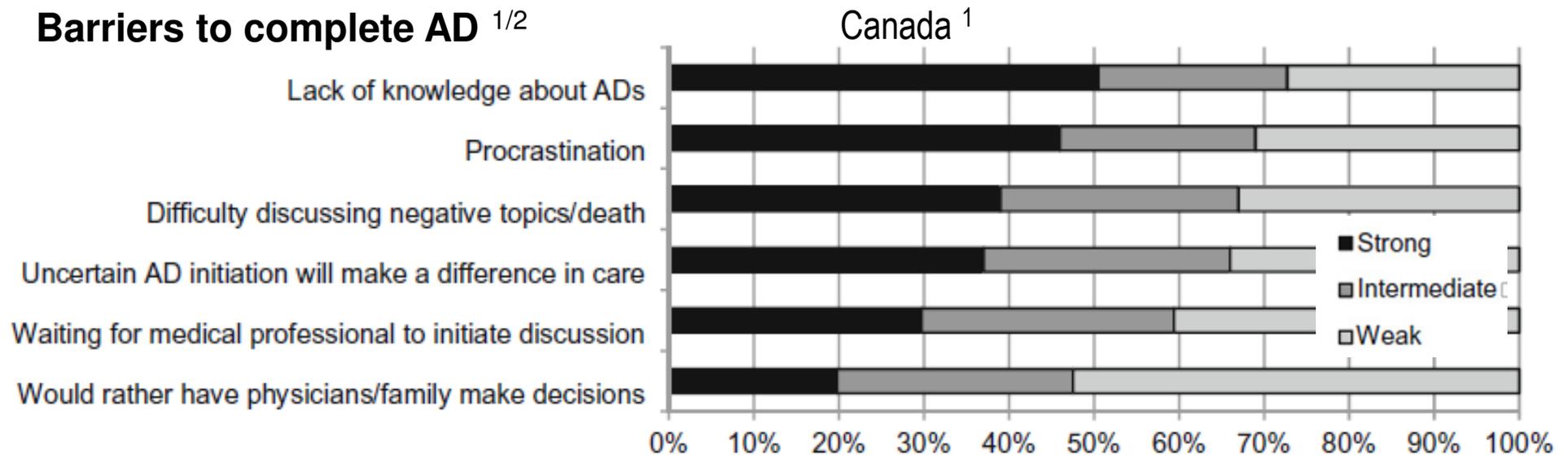
Canadian hospitals (n=12), 278 pts (54% of approached, dying risk ≤6 mts high; 80 y), 225 family members (62%; 61 y). 76% pts thought about EOL-care, 48% ACP, 73% named surrogate DM. Pts discussed wishes: 30% involved physician, 55% any HCP; document in medical record 30%



Heyland DK, et al. *JAMA Intern Med.* 2013;173:778-87

Thinking about EOL >> ACP
Professionals poorly involved
 → **What are the barriers?**
 → **for AD (legal) or for ACP (clinical)**

Barriers to complete AD ^{1/2}



Israel all AD (legal doc n=1167 2007-2010) compared to country population: female (68% vs 57%), ≥ 85 years (28% vs 14%), Jewish (96% vs 89%), single not married (60% vs 65%) → is religion a barrier? ²

Concerns about AD: witnessed signatures needed, online hurdles, lawyers too important ³

«Delegalizing advance directives could make them more fluid, dynamic, and accessible tools for promoting patients' care preferences»

1: McDonald JC et al. Support Care Cancer 2017;25:523–31

2: Shvartzman P et al. JPSM 2015;49:1097-101 // 3: Rolnick JA et al. NEJM 376;22:2105-6

Barriers to complete AD ^{2/2}

Health care team members may have poor knowledge and skills in ACP ¹
Timing unclear in the disease trajectory: assessment of patients readiness by
Health Care Professionals is variable

Doubts: too simplistic approach to complex & dynamic decision making process ²

Systematic review on perceptions or experiences regarding ACP in cancer pts (n=40)³
Poor data: recruitment procedures, response rates, cross-sectional, few terminal pts

“What is needed is not increasingly elaborated and refined protocols and checklists,
but a continuing awareness of the key role of open ethical dialogue in the practice of
all aspects of clinical care” ⁴

1: Lovell A, Yates P. Pall Med 2014;28:1026-35 / 2: Johnson S et al. Roy Aus Coll Phys 2017:309-4
3: Johnson S et al. Psycho-Oncology 2016;25: 362–86 / 4: Komesaroff PA. Roy Aus Coll Phys 2017:359-60

Phase I trial participation shall NOT be a barrier to ACP

Cassel JB et al. J Pain Symptom Manage 2016;52:437-45

Role of Oncologist

Cancer patients trust their doctors¹:

Oncologists inform patients & facilitate EOL-Decision making²

Roles are debatable: primary physician or oncology team or palliative care specialist³

Pts' preferences for physician behaviours @ EOL communication: general wards canada, 70% cancer ⁴ Purposive, maximum variation sampling (n=16), ≥55 y, prognosis <1 year, interpretive description

- 1) '**knowing me**': family roles, life history on values and priorities
- 2) '**conditional candour**': assess pts' readiness, invited to conversation, sensitive information delivery

1,231 pts IV lung / ColoRect cancer: EOL-discussion (DNR or hospice) wt physician (88%) ⁵

Less aggressive EOL (p<.001; Chemoth <14days 16%, acute care <30days 40%, no hospice 42%)

1: Schildmann & Winkler Oncol Res Treat 2014;37:60 // 2: Schildmann et al. Ann Oncol 2013;24:2444-9

3: Interactive case (Tolle S, Back A, Meier D). NEJM 2015;372:667-70

4: Abdul-Razzak A et al. BMJ Open 2014;4:e005653

5: Mack JW et al. J Clin Oncol 2012

Conclusions

Advanced care planning is an integral part of cancer care delivered by cancer clinicians

Discussing formally Advanced Directives (with good documents including also patient values and decisional preferences) may help to discuss more in depth ACP

Oncologist & other cancer clinicians are important (and patients expect it) to deliver EOL-discussions and guide ACP

Discussing concrete steps for end-of-life preparation, is a key, evidenced-based communication intervention which shall be delivered together with preparing patients for the promises of modern oncology (prepare for the worst – hope for the best)

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Backup

Language

Australia: no difference of AD completion (54%) greek, italian or english-speaking pts¹

Religion

Systematic review, papers focusing on religion and major EOL-issues ²

AD: christianity (n=2; 4080 pts), Judaism (n=2; 44 pts), Islam (n=5; 691 pts),
Hinduism (n=5; 605 pts), Buddhism/Taoism (n=2; 143 pts), multiple (n=2; 4230 pts).

Most studies cross-sectional / questionnaire surveys

Receptivity to advanced directives is greatest among Roman Catholic, Protestant,
Jewish, and Hindu populations

Variability in european countries

Cross-sectional, retrospective survey of deceased patients, treated in GP-networks, n=4396 ³

Italy (n=1808; 46% cancer), Spain (379, 37%), Belgium (1556, 37%), Netherlands (653, 52%)

- Discussion of treatment preferences IT 10% SP 7% BE 25% NE 47%

- Surrogate decision-maker assigned IT 6% SP 5% BE 16% NE 29%

Assoc fcts: Diagnosis discussion, # GP contacts (≥3), GP knows Pall Care, death place

1:Detering K, et al. BMJ Open 2015;5:e008800 // 2: Chakraborty R et al. Pall Supp Care 2017;15:609-22

3: Evans N et al. PLOS ONE 2013;8: e57965, 1-11

Challenges in different cultures

Medical decision making in China largely relies on the patients' families: latent moral risk that interests of vulnerable patients might not be met or be violated by their family members¹⁻³

Chinese study: 412 pts from 9 leading hospitals⁴

n=246: Refuse AD discussion (95% anticancer tx) (live in Village, p=.013, superordinate, p=.018)

n=166: Accept AD concept, signed to give up invasive tx when anti-cancer tx terminates 100%

- Participate in decision making: 24 vs not allowed by family to participate: 142

(better financial situation, p=.048; living in cities, p=.037; superordinate status in their families, p=.004)

(know diagnosis 100% vs 66%, stage 96% vs 29%, prognosis 96% vs 23%; p=.001)

Premature termination of anticancer therapy (61%, major cause: financial problems)

37 pts not aware vs 64 know: main predictor subordinate family status and decision making mode

(know diagnosis 30% vs 84%, stage 5% vs 48%, prognosis 8% vs 45%; p=.000)

African Americans (Systematic integrated literature review, n=38, moderate-low quality)⁴

→ prefer more aggressive care, engage less in ACP, like informally discuss EOL care not formal

1: Cheng KY et al. Bioethics 2012; 26:431-9 ;

2: Fan R. Theor Med Bioeth 2011; 32:301-13

3: Doering O. Formos J Med Humanit 2001; 2:48-66

4: Xing Y-F et al. Oncotarget 2017; 8:45391-8

5: Sanders JJ et al. J Pall Med 2016;19:202-28

Decision making preference & AD

Study west-USA
Age and education influence decision making preference
MD – shared - own

Characteristic	Doctor Makes Decisions (Low DCPs) <i>n</i> = 27	Share Decisions (Medium DCPs) <i>n</i> = 49	Make Own Decisions (High DCPs) <i>n</i> = 70	<i>P</i> -value
Age, mean ± SD	75.3 ± 10.7	68.9 ± 9.8	70.4 ± 9.1	0.03 ^a
Women, <i>n</i> (%)	10 (37.0)	19 (38.8)	31 (44.3)	0.77 ^b
Race/ethnicity, <i>n</i> (%)				0.28 ^b
White, Non-Hispanic	15 (55.6)	21 (42.9)	33 (47.1)	
African American	8 (29.6)	13 (26.5)	18 (25.7)	
Latino or Hispanic	1 (3.7)	4 (8.2)	5 (7.1)	
Asian or Pacific Islander	3 (11.1)	4 (8.2)	12 (17.1)	
Multiethnic, Other	0 (0.0)	7 (14.3)	2 (2.9)	
Education, <i>n</i> (%)				0.09 ^b
≤High school	6 (22.2)	11 (22.4)	6 (8.6)	

Advance Care Planning	Overall, <i>N</i> = 146 <i>n</i> (%)	Doctor Makes Decisions (Low DCPs), <i>n</i> = 27 <i>n</i> (%)	Share Decisions (Medium DCPs), <i>n</i> = 49 <i>n</i> (%)	Make Own Decisions (High DCPs), <i>n</i> = 70 <i>n</i> (%)	<i>P</i> -value
Prior care planning					
Decided on a surrogate decision maker	89 (61.0)	17 (63.0)	29 (59.2)	43 (61.4)	0.96 ^a
Completed an advance directive	69 (47.3)	10 (37.0)	27 (55.1)	32 (45.7)	0.21 ^a
Made life or death decision for self	63 (43.2)	9 (33.3)	21 (42.9)	33 (47.1)	0.32 ^a
Made life or death decision for others	52 (35.6)	7 (25.9)	16 (32.7)	29 (41.4)	0.33 ^a
Goals of care decisions: which statement do you most agree with?					
Life is always worth living	26 (17.8)	5 (18.5)	11 (22.5)	10 (14.3)	0.52 ^b
Some situations would make life not worth living	76 (52.1)	13 (48.2)	25 (51.0)	38 (54.3)	0.85 ^b
I am not ready to answer/not sure	44 (30.1)	9 (33.3)	13 (26.5)	22 (31.4)	0.78 ^b

→ Pts even with DM preference for doctor want to engage in ACP, readiness important to assess

Advanced directives (AD) can foster more End-of-Life Discussions

New AD forms (n=53) replaced DNR permission forms (n=53)

(1) time of EOL discussion

(2) life-sustaining treatment orders (cardiac massage, inotropes, defibrillation, mechanical ventilation, artificial nutrition / hydration, hemodialysis)

(3) living wills; (4) healthcare proxy designations.

(5) patient's permission for later administration of palliative sedation.

(6) space for patients to express their feelings or wishes to family

Concordance of wishes high
(Resuscitation [0], tube feeding [1], palliative sedation [7], renal replacement [0])

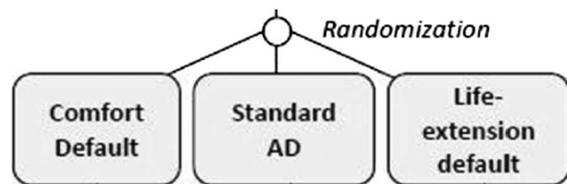
Factor	Adjusted odds ratio (95% CI)	p-value
Age (> 60 yr vs. < 60 yr)	2.919 (0.617-13.815)	0.177
Sex (female vs. male)	2.806 (0.462-17.031)	0.262
Education (≥ high school graduate vs. ≤ middle school graduate)	9.586 (1.355-67.788)	0.024*
Time from diagnosis to completion of advance directive (> 2 yr vs. < 2 yr)	70.312 (4.745-1041.883)	0.002*

Hong JH et al. Cancer Res Treat. 2016;48:753-8

Ongoing RCTs of Advance Care Planning in cancer care

Study name	Study design	Sample size	Population	Intervention	Primary outcome	Shared patient outcomes	Additional features of each study
ACTION Study ²⁷	Cluster RCT in 6 European countries (BE, DK, IT, NL, SI, UK)	1360	Patients with advanced lung or colorectal cancer with an average life expectancy of 12 months	Respecting Choices model	Quality of life and symptoms	Goal concordant care Quality of life Quality of death/quality of end-of-life (EOL) care Satisfaction with the intervention	Qualitative study of patients, relative's and professional caregivers' experiences of involvement in ACP
Bernacki <i>et al</i> ²⁶	Cluster RCT, USA	426	Patients with advanced incurable cancer and a life expectancy of <12 months	A multicomponent, structured communication intervention	Receipt of goal-concordant care, and peacefulness at the EOL	Timing, place and prevalence of documentation about EOL care Place of death	Clinician outcome data—attitudes, confidence, acceptability, prognostic evaluation
Australian ACP study	One-to-one randomisation RCT, Australia	210	Patients with advanced cancer, and a life expectancy of 3–12 months	Adapted Respecting Patient Choices model + prognostic information	Family/friend-reported: (1) discussion with the patient about their EOL wishes and (2) perception that the patient's EOL wishes were met	Resource use/cost analysis Bereavement outcomes in relatives	Estimating and discussing survival scenarios

3 Defaults allowing opt-in & opt-out



Gabler NB *et al.*
BMJ Open
2016;6:e010628

Bernacki R *et al.* BMJ Open 2015;5: e009032
ACTION: Rietjens JAC *et al.* BMC Cancer 2016;16:1–8
Johnson S *et al.* BMJ Open 2016;6:e012387

Decision aid research

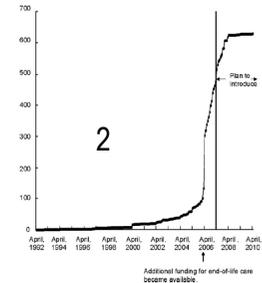
Butler M *et al.* Ann Intern Med 2014;161:408-18

Advanced directives (AD) completion vs EOL-Discussions

Belgian nursing homes (318, 1240 pts): AD (5%), physician orders (51%) ¹

Japanes nursing homes (913, RR 64%): AD in 58%

introduction related to *EOL-care funding* ²



Primary care pts (414) San Francisco VA Med Ctr: 51% AD (36% form, 33% discussion) ³

Outpt primary care (437) Veterans with AD, 61% assigned trusted person, only 67% AD in chart ⁴

Emergency room (682): 54% assigned proxy, 41% living will; in medical chart 4% / 4% ⁵

Cancer Ctr Canada (111 out-pts declined, n=193): AD 55%, living will 33%, PoA 49%, DNR 18% ⁶
(Before cancer dg: 53%, ~ income [p=.02], age [p=.004]; after Dg: ~ EOL-disc [p=.02], PC referral [p<.0001])

Radiotherapy Ctr Germany (3 year survey, RR 55%. 658 pts): **24% signed AD, 53% aim to**
(facilitate decision-making, 96%; ease relatives' burden, 99%; consultation aid not directive, 56%) ⁷

1: De Gendt C et al. JPSM 2013;45:223-34 // 2: Takezako Y et al. JPSM 2013;45:63-70

3: Walker E et al. JPSM 2017; Sept // 4: Garner KK et al. JPSM 2017;53:1-4

5: Grudzen CR et al. JPSM 2016;51:647-51

6: McDonald JC et al. Support Care Cancer 2017;25:523-31

7: van Oorschot et al. Support Care Cancer 2012; 20:2729-36

8: Anderson WG et al. *Qual Health Res.* 2013;23:3-13

Wish for EOL-disussions >>
completed AD >> in medical
charts: fear of doctors to talk? ⁸