

1.3 ACP in Oncology

O13

Evaluating experiences of Advance Care Planning facilitators: results from the international ACTION study

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Background: The ACTION trial evaluates the effect of the ACTION Respecting Choices (RC) advance care planning (ACP) intervention in patients with advanced cancer in six European countries. Systematic evaluations of such ACP conversations by facilitators are currently lacking. We developed and applied a 10-item facilitator-reported instrument.

Methods: The instrument asked about the facilitator's perception of the patient's and the personal representative's (PR) reactions to and engagement with the intervention and satisfaction with the intervention.

Results: From March 2016 until February 2018, 272 conversations took place. Of these, 265 were evaluated.

According to the facilitators, 32% of the patients did not appear to understand all questions asked (29% understood most, 3% understood about half), and 36% were not able to answer all questions (31% answered most, 4% answered about half, 1% answered fewer). Furthermore, 38% of the patients and 27% of the PRs did not appear to perceive all questions as OK (patients: 33% perceived most as OK, 3% about half, 2% fewer; PR: 24% most, 3% about half). Facilitator perception of patient satisfaction, PR satisfaction and their own satisfaction with ACP conversations ranged 40-54% for 'very much', 41-49% for 'quite a bit' and 5-11% for 'a little'.

Conclusion: To our knowledge, this is the first clinical trial to systematically evaluate the feasibility of ACP conversations from the facilitator perspective. Parts of the ACP intervention appeared to be challenging for patients and PRs. These results, together with qualitative data, will help understand the outcomes of the ACTION trial. Funding: EU's FP7.

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Effects of implementation of a standardised Palliative Care Pathway for patients with advanced cancer in a Dutch hospital

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Background Early integration of oncology and palliative care has been recommended as a major strategy to improve patient outcomes at the end of life. A standardised palliative care pathway(PCP) may be useful to support such integration. We studied whether implementation of a PCP had an effect on place of death, hospitalisations, and documentation of advance care planning.

Methods

In a single centre pre- and post-intervention study, data were collected for adult patients with cancer who had been treated at inpatient or outpatient clinics and died between February 2014 and February 2015 (pre-PCP period) or between November 2015 and November 2016 (post-PCP period).

Results: 852 patients were included, 426 in each study period. The PCP was used for 237 patients (56%) after implementation. The PCP was started 33 days (IQR 12-74days) before death. 76% and 77% of the patients died outside the hospital in the pre- and post-PCP period, respectively (p=0.57). No differences were found for hospitalisations in the last 3 months of life. In the pre-PCP period, bad-news conversations (75% and 62% respectively, p<0.001) and preferred place of death (47% and 32% respectively, p< 0.001) were documented more often, whereas a DNR code was more often documented during the post-PCP period (79% and 89% respectively, p<0.001).

Conclusions: A high percentage of patients died outside the hospital in both groups, not increased by implementation of the PCP. Start of a PCP in the last two months of life may be too late to facilitate ACP.

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Patients' Readiness for Advance Care Planning Conversations: a Qualitative Study as part of the ACTION Study

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Background: Patients and healthcare professionals describe patients' readiness for advance care planning (ACP) as an indicator for whether or not to start ACP conversations. Nevertheless, it is unclear how readiness manifests

and develops throughout an ACP conversation. This study explores patients' readiness during an ACP conversation. **Methods:** A qualitative study using content analysis of structured ACP conversations between a trained facilitator, a patient with advanced colorectal or lung cancer and a relative. Conversations were conducted in the Netherlands as part of the international ACTION trial. Analysis was supported by NVivo 11.

Results: Transcripts of thirteen ACP conversations were included. All patients expressed both signs of not being ready and being ready within one conversation. Signs of being ready included answering questions on a personal level or demonstrating a realistic understanding of one's disease. Signs of not being ready included limiting one's perspective to the here and now or indicating a preference not to talk about an ACP-related topic. Signs of not being ready were especially seen when future oriented topics such as 'complications' and 'hope' were discussed. Patients could more easily elaborate on less future orientated topics as 'good life' and 'earlier experiences with illness'. Despite signs of not being ready patients were able to continue the conversation.

Conclusion: Patients do not have to be ready for all elements of ACP to be able to participate in an ACP conversation. Healthcare professionals should be aware of patients' ability to alternate in readiness depending on the topic that is discussed.

O16

Let's talk about death: Gender effects in cancer patient's preferences for end-of-life

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Background: Males receive more aggressive care near death. End-of-life (EOL) conversations can protect from aggressive care near death and support more consistent EOL care. Therefore, information about gender effects on engagement in and realization of EOL conversations are needed.

Methods: In a cross-sectional study 186 cancer patients from an university and rehab hospital were asked about their preferences for EOL discussions using a semi-structured interview, focusing on a) the importance of six different EOL issues (medical and nursing care, organizational, emotional, social and spiritual/religious aspects), b) the desired time point, c) mode of discussion initiation.

Results: The importance of EOL topics differ significantly by issue ($p=.002$, $\eta^2=.02$) and gender ($p<.001$, $\eta^2=.11$). Females want to speak more about nursing care, emotions, social and religious aspects. Males wish to avoid the engagement in EOL issues and conversations. They prefer to be addressed only about nursing and medical care, whereas females want to be addressed about all EOL topics. Independent of gender, the majority of patients prefer to talk rather late: When the disease is getting worse (58%) or at the end of their palliative therapy or self-sufficiency (27.5%).

Conclusion: Because of distinct gender differences for engagement in and realization of EOL conversations a gender sensitive approach is recommended. Independent of gender, the tendency of patients to talk late about EOL issues should be considered to reduce the risk of delayed or neglected EOL conversations. Therefore, a two-step approach of end-of-life conversations is suggested.

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The Stability of Treatment Preferences among Patients with Advanced Cancer

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Background: Stability of patients' treatment preferences has important implications for advance care planning, among which its timing. We therefore examined the stability of preferences and its predictors of patients with advanced cancer.

Methods: In this cohort, 104 patients with metastatic cancer and an oncologist estimated life-expectancy of \leq six months participated in interviews following clinical visits in which patients' recent scan results were discussed. Interviews were repeated in three monthly follow-ups. At baseline, patients' age, education, sex, race, marital status, insurance status, and type of cancer were documented. At each assessment, patients reported their treatment preferences (i.e. trade-offs of life-prolonging versus comfort care), quality of life, and illness understanding.

Results: At baseline ($n=104$), 55 (53%) patients preferred life-prolonging care, 49 (47%) preferred comfort care. Patients were followed for one ($n=104$), two ($n=74$), or three months ($n=44$). Between baseline and month I, 84 patients (81%) had stable treatment preferences. During follow-up, preferences of 71 patients (68%) remained stable (equally divided between a consistent preference for life-prolonging and comfort care). Treatment preferences of 33 (32%) patients changed at least once during follow-up. Patients' preferences at baseline strongly predicted preferences at month I (OR=17.8; CI=6.7-47.3; $p<.001$). Patient characteristics, quality of life, and illness understanding at baseline were not significantly associated with stability of preferences at month I.

Conclusion: Two-thirds of patients with advanced cancer had stable preferences regarding life-prolonging versus comfort care. Changes of preferences were often unpredictable. Our findings suggest potential benefits of ongoing communication about preferences, including advance care planning.

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Communication issues and challenges of Advance Care Plan in Two African Hospitals.

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Advance care plans (ACP) for patients is an integral part of End of life care services but very challenging in most African clinical settings. Several factors mitigating against its successful implementation include the culture and communication skills. Discussion around death and dying in most African communities is a taboo and an awkward narratives for the majority of the clinicians with little or no skills to facilitate such discourse.

These challenges were explored among patients suffering from life-limiting illnesses in two Nigeria and South Africa hospitals by surveying the clinicians way of handling the issues and the patients and families attitudes towards ACP.

Methodology: A retrospective evaluation of case notes of cancer patients attending FMCAbeokuta, Nigeria were surveyed. A prospective second phase of the study using a questionnaire tool was administered on patients attending both the FMCA and Victoria Hospital Wynberg, Cape Town, South Africa services to explore their experiences and discussion around the ACP.

Results and Lessons learnt: The FMCA survey revealed none of the reviewed case notes recorded ACP discussion with the patients and if actually done were never documented. The prospective studies further confirmed initiating advance care plan discussion is a big challenge and more daunting process in both African settings. The cultural and incompetent communication skills should be addressed with good public sensitisation and advocacy and also need to empower the clinicians. Mandatory policy that integrates ACP into our routine 'informed consent' for all our clinical activities maybe another good option to initiate such discussion with the patients.