End-of-Life Decision Making in Hematopoietic Cell Transplantation Recipients

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Discussions about futile treatment options for patients undergoing hematopoietic cell transplantation (HCT) can be difficult for healthcare providers. These discussions often are not initiated before transplantation, but only after a patient’s healthcare status deteriorates. Nurses are in a key position to provide support and advocate for patients and their families in end-of-life (EOL) decisions. A need exists for increased autonomy for nurses as patient advocates. Implementation of multidisciplinary nursing education, both in schools and in the workplace, will support these new responsibilities. This article will provide a review of the literature related to the nurse role in the transition from active treatment (aggressive care) to EOL care in the HCT population.

Decision making in health care often involves balancing the risks and benefits among multiple options (Tariman, Berry, Cochrane, Doorenbos, & Schepp, 2012). In oncology practice, patients undergoing hematopoietic cell transplantation (HCT) often are faced with the difficult task of balancing the risks and benefits of treatment. The authors of this article sought to examine the literature regarding factors that affect decision making and treatment decisions for patients undergoing HCT, and to examine nurse roles in the treatment and care of that population.

HCT has become standard care for many cancer diagnoses, and nursing care is critical for the success of these complex transplantation treatment modalities. Nurses administer the treatment medications, assess and monitor patient responses to treatment, and manage psychological needs and treatment effects before, during, and following HCT. Unfortunately, HCT becomes a final treatment option for some patients who need to be informed of the possibility of an unfavorable response to treatment. Literature and clinical observations suggest that discussions about futile treatment options can be difficult for some healthcare providers and often are not initiated before transplantation but, rather, only after a patient’s healthcare status deteriorates (Adams, Bailey, Anderson, & Docherty, 2011). Futile treatment is commonly referred to as “treatment that is unable to reverse the course of the disease and that offers no hope of benefit” (Coveney, 2007, p. 68). End-of-life (EOL) care is an area in which nurses are well-positioned to take the lead in developing patient- and family-centered interventions targeted at improving care during this significant part of their patients’ lives.

National guidelines recommend advanced care planning (ACP) for patients with terminal illness who have a life expectancy of less than one year (National Comprehensive Cancer Network [NCCN], 2010). However, despite the relatively high transplantation-related mortality of patients undergoing HCT, EOL care is a poorly understood issue, and the problems of providing palliative care to patients undergoing transplantation may be underestimated. According to Keating et al. (2010), some physicians who are aware of the ACP guidelines for terminally ill patients may delay EOL discussions because they fear discussing death early in a patient’s terminal course may be associated with less hope and poorer outcomes. Research also suggests that physicians delay discussing EOL options while patients still feel well and may, instead, wait for the onset of
symptoms or until no further non-palliative options are available (Keating et al., 2010). Unfortunately, most patients do not have ACP and continue to receive chemotherapy during the last month of life, with only a minority (20%–40%) using hospice care (Zhou, Stoltzfus, Houldin, Parks, & Swan, 2010).

Methods

The authors of the current article searched the CINAHL®, MEDLINE® (PubMed), and SCOPUS electronic databases for all available dates to identify literature published using a combination of keywords and subject headings. Subject headings included palliative care, decision making, advanced care planning, stem cell transplantation, bone marrow transplantation, witholding treatment, treatment failure, and oncologic nursing. Keywords included cancer nurs* and transplant* and ventilat*. These searches resulted in 409 articles that matched the question, “What is the nurse’s role in the transition from active treatment (aggressive care) to EOL care in HCT patients?”

Because of the limited research conducted on this question specifically related to the HCT population, the authors expanded the search to include the adult cancer population. Inclusion criteria for the review were English-language studies, occurring in patients with cancer (any type), that addressed families making critical decisions regarding the psychological, social, legal, physical, and ethical aspects of improving EOL care. The authors did not limit the selection to articles that only addressed the nurse role in the transition to EOL care because of the lack of research conducted on only the nurse role. The authors excluded articles that reported research on pediatric cancer populations. Of the 409 articles, 90 articles were selected that addressed a facet of the research question. These were evaluated by study design, setting, and significant findings. An additional five articles were selected for inclusion after reference lists from previously collected articles were reviewed.

A second search looked for published guidelines and established definitions for palliative care and EOL care. Guidelines included in this review were from the NCCN and the National Guideline Clearinghouse. The authors organized results into five categories for palliative care and EOL care: ethical principles, decision making, implications for nursing practice, implications for nursing education, and implications for nursing research. The following sections provide discussions related to each category.

Results and Discussion

Palliative Care and End-of-Life Care Definitions

The terms palliative care, EOL care, hospice care, and supportive care need to be more clearly defined to avoid confusion among healthcare providers, patients, and caregivers. The World Health Organization (2002) has defined palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. This approach includes prevention and relief of suffering by means of early identification and assessment as well as treatment of pain, and physical, psychosocial, and spiritual problems. Such care must be regarded as integral and essential elements of a national cancer control program, regardless of the possibilities of cure (World Health Organization, 2002). The NCCN (2010) palliative care guidelines identified the goal of palliative care, which is to prevent and relieve suffering and to support the best possible quality of life for patients and their families (see Table 1), regardless of the stage of the disease or the need for other therapies.

The term EOL care often is used interchangeably with hospice care and was originally associated with a time-defined aspect of care provided to terminally ill patients and their families (Kuebler, Lynn, & Von Rohen, 2005). Berger, Portenoy, and Weissman (1998) defined supportive care in oncology as those aspects of medical care concerned with the physical, psychological, and spiritual issues faced by patients with cancer, their families, their communities, and their healthcare providers. In this context, supportive oncology describes both those interventions used to support patients who experience adverse effects caused by antineoplastic therapies and those interventions now considered under the broad rubric of palliative care.

Ethical Principles

Ethics is an integral part of the foundation of nursing (American Nurses Association [ANA], 2001). The ANA code of ethics is composed of nine provisions related to the care of patients and families.
Decision Making: Living Will and Advance Directives

Advance directives are legal documents that express a patient’s wishes about what his or her medical care should be if the patient is unable to communicate. The healthcare team must be well informed about these documents and have access to them. Although providers at all healthcare facilities are required to present advance directive information to their patients, 85%-95% of the U.S. population does not have an advance directive in place when entering the healthcare setting (Alfonso, 2009). However, studies do suggest a higher prevalence of advance directives in patients with cancer than in any other group (Joffee, Mello, Cook, & Lee, 2007).

In a study of 155 patients undergoing HCT by Joffee et al. (2007), 69% had designated a healthcare proxy, 44% had completed a living will, 61% had an estate will, and 65% had discussed their wishes regarding life support with family and friends. However, only 16% had discussed their wishes regarding life support with their clinicians, and only 39% had actual written advance directives in their charts. In addition, documentation of a discussion between patients and clinicians regarding the elements of ACP was rare (Joffee et al., 2007). ACP is not a one-time conversation; rather, multiple parties may be included in the ongoing process throughout treatment. Healthcare providers should consider the cultural, familial, and religious beliefs that may affect patient and family willingness to discuss EOL care and to participate in decision making.

Efficacy of Hospice

In the United States, Medicare and insurance agencies limit hospice to the last six months of life, which is a barrier to efficacy because death cannot be predicted accurately (Ferrell & Coyle 2005). Other barriers include lack of education and reluctance to disclose, discuss, or acknowledge a patient’s impending death, because doing so is considered giving up on a patient. The highest-rated barrier is knowledge deficit, noted by 90% of the hospice staff and physicians in a study by Johnson and Slaninka (1999). Nurses with hospice training reported greater perceived role responsibility and comfort levels in initiating discussions about EOL issues (Cramer et al., 2003).

Clinician-Patient Communication

Bradley et al. (2000) found that nurses frequently did not initiate discussions on critical EOL issues, preferring that the medical staff do so, which could result in delays of hospice referrals and depriving many terminally ill patients and families of the benefits of hospice services.

Implications for Nursing Practice

Nurses are at the forefront in rendering optimal care in various stages of patient illness. When patients are given options about where to receive treatment, they often will seek their caregivers’ or their medical practitioners’ advice in EOL decision-making. Nurses, compared to other members of the healthcare team, have more interaction with patients who are facing death and are in a key position to provide support and to advocate for patients and their families in EOL decisions (Thacker, 2008). Trust that comes from truthful talking about
the patients’ prognosis and treatment is an integral element of the nurse-patient relationship (Starzomski, 2009), and yet many nurses fail to advocate for their patients regarding EOL decisions because of fear that conflict may occur (Thacker, 2008). Health-care personnel must be educated to help provide the needed patient support (Starzomski, 2009). A systematic review of 28 studies by Murray, Wilson, Kryworuchko, Stacey, and O’Conner (2009) indicated that nurses believe that supporting patients in their decision making is a vital component of patient-centered care, yet many nurses feel they lack the skills, confidence, and tools to help provide the needed support. Some studies also indicate that nurses believe that patients should be involved in making decisions about their care. However, nurses also indicated that they continue to be uncomfortable in discussing EOL care with patients, and the main learning need identified by oncology nurses is knowing how to talk with dying patients (Murray et al., 2009).

Although more patients die in a hospital than at home, many terminally ill patients and their families report dissatisfaction with EOL care (Moskowitz & Nelson, 1995). Rolland and Kalman (2007) found that a higher satisfaction with EOL care exists when healthcare efforts are focused on quality of life, which is the goal of hospice and palliative care. Unfortunately, few individuals benefit from this service because of delayed referrals (Rolland & Kalman, 2007). Rolland and Kalman (2007) showed that many patients were referred too late to use hospice services effectively because many patients died within one week of admission to hospice. Early referral to hospice or palliative care is imperative to improve dying patients’ quality of life. Therefore, examining nurse attitudes about EOL care and their role in EOL care is imperative. Rolland and Kalman’s (2007) research on measuring clinician attitudes about how EOL care can help inform patients of their situations, evaluate interventions, and improve care for the dying. This was based on three concepts: professional responsibility, efficacy of hospice, and clinician-patient communication (see Figure 1).

**Nurse role in promoting self-care for patients:** The nurse is the key healthcare professional to bring forth supported self-care. The issues described in clinical education, symptom-focused interventions, and preparation for death interventions could be addressed using minimal resources and time (Johnston et al., 2009). According to Johnston et al. (2009), self-care strategies for patients with advanced disease should be related to assisting patients with managing pain and other symptoms that impact their quality of life, such as adapting psychologically and emotionally to their illness and relieving distress associated with symptoms that cannot easily be altered. In addition, they suggested that future self-management programs should be planned for patients with advanced disease who are dealing with EOL care. Optimally, self-care in the future should be created from patient-initiated and patient- and family-centered evidence. Suggestions include adapting components of patient- and family-centered models of care to specific patient care populations through nurse and physician dyads, nursing council initiatives, and ethics and practice committees.

McCorkle et al.’s (2011) Chronic Care Model (CCM) characterizes the profile of effective communication between informed, motivated patients on the one hand and well-organized, dedicated healthcare provider teams on the other. The CCM embodies the characteristics of a healthcare system that promotes high-quality care. These characteristics include six elements: assistance with self-management, planning of a delivery system, guidance with decision making, organization of clinical information, establishment of health care, and agencies of support from the community (Coleman, Austin, Brach, & Wagner, 2009; Wagner et al., 2001). Some oncology practices today include features of the early CCM, including a focus on more effective communication, organization of clinical information, guidance with decision making, and identifying support from the community to assist their patients and families with self-management skills.

Progress has been made in developing ways to help patients deal with cancer symptoms during the therapy stage of the cancer care continuum. Initiatives for self-management of physical symptoms and psychological distress have been a factor in this advancement. An immediate necessity exists to translate these self-management interventions into clinical practice. Few studies have evaluated the usefulness and advantage of self-management interventions during the post-treatment and EOL stages of the continuum. The studies recommend that

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**TABLE 2. The Six-Step SPIKES Protocol**

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
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<tr>
<td>1</td>
<td>Set up the interview by arranging privacy, involving the family, making a connection with the patient, and managing time constraints and interruptions.</td>
</tr>
<tr>
<td>2</td>
<td>Assess the patient’s perception with open-ended questions to determine the understanding of his or her medical condition.</td>
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<tr>
<td>3</td>
<td>Determine the patient’s readiness to receive full disclosure of illness. If a patient refuses to know the details, the clinician should convey to the patient that he or she can talk to other family members or is available to sit with the patient whenever ready.</td>
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<td>4</td>
<td>Use words such as “I’m sorry to tell you . . .” to warn a patient of upcoming news and to decrease his or her shock. It also is vital to use simple, nontechnical words such as “spread,” instead of “metastasized”; avoid too much bluntness; provide information in small portions; and continue to monitor the patient’s understanding of his or her situation.</td>
</tr>
<tr>
<td>5</td>
<td>Address the patient’s emotions with empathic responses. This involves four steps: observing a patient’s emotions after hearing the bad news, identifying the emotions by using open-ended questions to validate what the patient is thinking or feeling, recognizing the explanation for the emotions, and informing the patient that the clinician understands his or her feelings.</td>
</tr>
<tr>
<td>6</td>
<td>Inquire of a strategy and summary for the patient to feel that his or her wishes are important. The oncologist should ask the patient about future plans and be willing to listen to the treatment plan. The decision making should be a joint responsibility between the clinician and the patient, and the clinician should make sure the patient understands all discussions to minimize misinterpretation of the purpose of treatments.</td>
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**SPIKES—Set up interview, assess patient Perception, obtain patient Invitation, provide Knowledge to patient, address patient Emotions, and inquire about patient Strategy**

*Note. Based on information from Baile et al., 2000.*
the stage of the cancer care continuum directs the overall framework for patient and family decisions on how to manage their own care. For example, McCorkle et al. (2011) proposed that by using the CCM, oncology practice teams can become “practice homes” for their patients. In these homes, “proactive oncology practice teams can use the self-management interventions to enable and empower patients and families to care for themselves across the cancer care continuum in the way they prefer” (pp. 58–59).

Implications for Nursing Education

Clearly, an enormous need exists for more dialogue about ethical issues across disciplines. Nurses, in particular, frequently report that additional education is in critical demand in this area (McLennon, Uhrich, Lasiter, Chamness, & Helft, 2013). In response to this need, the American Association of Colleges of Nurses and the City of Hope National Medical Center partnered together to create the End-Of-Life Nursing Education Consortium (ELNEC) program to provide nurses with training, information, and resources about EOL care. Similarly, the Respectful Death Model established an EOL curriculum for family practice residents that describes how to discuss death with patients and posits that EOL care should begin when the professional determines that a patient could die within a year (Wasserman, 2008).

Research suggests that communication skills can be taught. Baile et al. (2000) collected information at a 1998 national oncology meeting on communication skills aimed at delivering bad news to patients. Based on their results, they devised a six-step protocol represented by the SPIKES acronym (Set up interview, assess patient Perception, obtain patient Invitation, provide Knowledge to patient, address patient Emotions, and inquire about patient Strategy) that has been noted to increase practitioner confidence in their ability to disclose unfavorable medical information to patients (see Table 2). Overall data suggest that patients want the amount of information they receive to be tailored to their preferences (Baile et al., 2000).

Mahon and McAuley (2010) proposed a critical need to equip nurses with extensive education and clinical experience in palliative care, something not routinely included in nursing and medical curriculums at present. Because the subject is poorly addressed in healthcare institutions and schools, a need exists to bring education to the workplace. Although education by itself is not likely to alter practice, valuable clinical resources combined with education efforts will help achieve much needed changes in practice.

Implications for Nursing Research

More research is needed to discover how changes in practice affect and are affected by barriers across individuals, practices, professions, and institutions. Dudgeon et al. (2008) suggested that two methods exist where more research is needed for supportive palliative care within a continuous quality improvement model: improving standards in oncology and initiating palliative care triggers that promote palliative care consultations.

More research also is needed regarding how patients cope with their illness at the EOL. Johnston et al. (2009) conducted a systematic literature review that revealed three main themes: interventions for EOL care, self-care behaviors used by patients, and factors that prevent patients from self-care. These authors...
Implications for Practice

- Offer support and serve as advocates for patients and their families to make important decisions on palliative and hospice care.
- Receive education and training to enhance comfort levels while discussing end-of-life issues with patients and their family members.
- Introduce advanced care planning and end-of-life issues with patients with cancer when they initially present for evaluation.

Conclusions

Although the concept of palliative care for patients undergoing HCT remains controversial to some healthcare providers, evidence indicates a need for changes in the direction of palliative care within this patient population. In summary, the literature reviewed supports several main tenets: a need for interprofessional education, acknowledgment that nurses should have increased autonomy and responsibilities as patient advocates, and a need for more multidisciplinary discussions to determine what barriers exist to prevent the use of current guidelines. More rigorous research is needed to evaluate beliefs and trends in this area of practice, particularly since research has indicated a reluctance on the part of HCPs to initiate EOL discussions.

The authors gratefully acknowledge Luanne Jorewicz, BA, scientific editor in the Department of Scientific Publications at MD Anderson Cancer Center, for her assistance with the preparation of this manuscript.

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