Advance Care Planning and Goals-of-Care Decisions Among Veterans With Malignancy

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BACKGROUND: There is a limited knowledge base about factors affecting advance directives and code status decisions among veterans with malignancy. In addition, few studies have focused on the benefit of palliative care (PC) in goals-of-care discussions among veterans with cancer.

OBJECTIVES: This study examined advance care planning and goals-of-care decisions among veterans with malignancy.

METHODS: Demographic and clinical data were obtained using retrospective chart analysis. Patient characteristics were analyzed using univariate descriptive statistics. To compare patients with and without a do-not-resuscitate (DNR) decision, chi-square test was performed.

FINDINGS: More than half of the patients in the study were referred to PC within one year of their cancer diagnosis. Most had documented metastatic disease at the time of their PC referral. Veterans with prostate cancer were more likely to elect full code status. In this study, White veterans were more likely to choose a DNR order than African American veterans.

LITTLE IS KNOWN ABOUT FACTORS THAT MAY CONTRIBUTE to advance directive (AD) and code status decisions among the veteran population. There is a limited knowledge base about demographic, disease-related, and social factors that may influence AD discussions among veterans with malignancy. This study examined the role of palliative care (PC) in facilitating AD discussions among veterans with cancer.

The International Association for Hospice and Palliative Care (2019) defines PC as the holistic care of individuals of all ages who have health-related suffering caused by severe illness, including those near the end of life (EOL). PC is dedicated to improving the quality of life of patients, their families, and their caregivers (Radbruch et al., 2020). PC as a model of care in clinical oncology improves understanding of illness, quality of life, and healthcare resource utilization, in addition to clarifying goals of care (GOC) for patients (Agarwal & Epstein, 2017).

ADs are written documents that allow patients to exercise prospective autonomy and make decisions about their care in anticipation of being unable to engage in medical decision-making either because of a temporary or permanent condition (D'cruz, 2021). ADs include instructions for healthcare providers on how the person would and would not want to be treated. In addition, ADs appoint a designated surrogate decision-maker if the patient cannot make their own healthcare decisions (D'cruz, 2021).

Agarwal and Epstein (2017) have reported that PC for patients with cancer improves patient well-being and satisfaction with care, as well as enhances care and prognosis discussions by clarifying patient understanding of illness, personal values, and future expectations. PC also supports improved survival outcomes, patient quality of life, and utilization of healthcare resources at EOL (Agarwal & Epstein, 2017). A review conducted by Dowling et al. (2020) concluded that the benefits of ADs include "less stress for patients and families alike, less burden, and less residual guilt for a surviving relative and an overarching prevention of 'crisis' decision-making" (p. 1,188).

A study conducted by Bischoff et al. (2018) reported that one-third of PC inpatient consultations were requested for advance care planning (ACP) and GOC. In addition, ACP and GOC were identified during the consultation for study participants who were referred for other reasons, including symptom management. Although ACP and GOC were addressed, only 3% of the study participants were discharged with a completed AD (Bischoff et al., 2018).

In a study comparing patients with hematologic malignancy to patients with solid tumors, patients with less PC were associated with fewer ACP