A Review of "Challenging Situations When Administering Palliative Chemotherapy—A Nursing Perspective"

Nancy G. Houlihan, MA, RN, AOCN®

The December 2014 issue of the *European Journal of Oncology Nursing* published an article by Näppä, Rasmussen, Axelsson, and Lindqvist that reported on a qualitative study of the challenges experienced by Swedish nurses when administering palliative cancer treatment at the end of life. The study identified the various clinical scenarios that create dilemmas among nurses. The authors described why chemotherapy at the end of life has become so prevalent and offered strategies to minimize or prevent the moral distress that can occur. Research from the United States identified similar trends in end-of-life treatment and supportive recommendations for multidisciplinary palliative care team collaboration as a solution.

Cancer Treatment During End of Life

Oncology nursing requires ongoing reflection on the moral and ethical decisions about cancer treatment, particularly as the ability to cure a patient is diminished by disease progression. Relationships with patients and families and their treating oncologists affect how nurses deal with their responsibilities and conflicting concerns about what is best for the patient. The dilemmas most frequently occur regarding chemotherapy treatment toward the end of life. Chemotherapy infusion nurses regularly treat patients with goals unrelated to cure. The uncertainty that they experience about their role can lead to moral distress because of administering potentially toxic agents with questionable outcomes to vulnerable patients (Sun, 2010).

Study on Palliative Chemotherapy Treatment

Näppä et al. (2014) explored the experiences of nurses when administering palliative chemotherapy to incurable patients. Palliative chemotherapy treatment (PCT) was described as treatment that is unable to cure cancer but is intended to decrease harmful symptoms, tumor burden, and pain, as well as increase quality of life and prolong life. Indications for PCT use was defined as expanding and prolonging survival and improving quality of life for patients with chemotherapy-sensitive tumors.

The qualitative study was conducted at eight hospitals in northern counties of Sweden, all collaborating with a university hospital. Practice in these hospitals required nurses to make judgments about patient suitability for PCT. Because a resident oncologist did not work on site to examine patients before each treatment cycle, nurses assessed patients for symptoms, such as weakness, development of a contraindicated condition for continuing treatment, and risk of greater harm than benefit. The nurses reported to the prescribing oncologist any change in condition that would necessitate a change in the plan to adjust, pause, or withdraw PCT. No palliative care team was involved in decision making at the time.

Seventeen nurses from 11 units, representing the eight hospitals, took part in the study. All had at least two years of experience (with a mean of 13 years) with PCT administration. All participants were women, and ages ranged from 27–63 years, with a mean of 48 years. Data were collected by interviewers who encouraged storytelling of specific patient encounters involving PCT that the nurses found challenging. The participants told a total of 28 stories. All stories contained more than one of the following content areas of dilemma: the nurse's relationship with the patient; the patient's general condition and appearance; the possibility of reflecting with the patient, family, and physician; and a retrospective judgment about the meaningfulness of the PCT.

Storytelling About Palliative Chemotherapy Treatment

Eight stories related to terminating treatment were determined to be uncomplicated without dilemma because the patient, family, nurse, and doctor had discussions and were in agreement with the decision. The other 20 stories were associated with dilemmas that were categorized into story lines: (a) the nurse felt that PCT was the right decision, and treatment was given but resulted in the nurse feeling it was wrong because the nurse had expected things to improve, and the patient died; (b) the nurse felt unsure about whether PCT was the right decision, but treatment was given, and the nurse felt that the decision was wrong because the patient's condition deteriorated; and (c) the nurse felt unsure about PCT, but treatment was given and the nurse felt that the decision was right because the patient's condition improved or the patient experienced a positive psychological benefit. The dilemmas were sorted into three interwoven areas, which included the uncertainty of the outcome when giving toxic drugs to vulnerable patients, the difficulty of resisting giving PCT to patients who want it, and insufficient communication between the nurses and doctors.

Ethical Conflicts

The unforeseeable outcome of PCT and the dilemmas experienced by nurses have not been well described in the literature, but Näppä et al. (2014) reported

ONF, 42(3), 319–320.
doi: 10.1188/15.ONF.319-320

narratives of nurses' clinical experience that affirm the existence of these dilemmas. Näppä et al. (2014) described how nurses can be "stuck in the middle" between patients, relatives, and physicians having neither the power nor knowledge to act according to their own perception of what is right. When the doctor has not had a discussion about dying with a patient, the nurse faces the moral difficulty of talking to patients about ceasing or delaying PCT even if he or she believes it to be in the patients' best interest. Patients tell nurses different stories, leading to differences in attitudes. Nurses question PCT more often, think more about how patients choose to live, and have a better understanding of feelings. Nurses often do not take part in decisions concerning PCT, prognosis, and treatment goals, but they have to implement treatment and live with the ethical conflicts.

Use of Palliative Chemotherapy Treatment

In Europe and the United States, the use of PCT is rising. Examination of Medicare beneficiary data shows that 25% of cancer decedents received chemotherapy during the last six months of life and 20% received chemotherapy during the last three months of life (Emanuel et al., 2003). Patients with cancer types known to be unresponsive to chemotherapy were just as likely to receive PCT as those with chemotherapy-sensitive tumors. Many reasons have been identified for using chemotherapy with very limited potential benefits. The discussion about changing to supportive care is difficult and time consuming, and physicians prefer to offer another chemotherapy regimen to avoid taking away patients' hope. These regimens are often based on anecdotal experience of success with other patients. PCT can offer improved symptom control and better quality of life, and the intent to lessen the negative effects of symptoms is a valid use of PCT at the end of life. The uncertainty in predicting treatment outcomes for individual patients is described as a reason to continue treatment, even in a late palliative phase, if the patient wishes to do so; however, patients rarely understand the true prognosis and have unrealistic expectations about the benefits (Earle et al., 2008).

Collaboration With Multidisciplinary Teams

Näppä et al.'s (2014) study, along with other research in the supportive and palliative care literature, stresses the importance of collaboration with multidisciplinary palliative care teams when prescribing PCT. This collaboration can provide better physical and emotional symptom control and less distressed decision making. Early introduction of palliative care in patients with advanced cancer receiving chemotherapy can lead to improved quality of life, mood, and length of survival. The use of palliative care specialists in oncology is growing and is included in care standards by organizations such as the American Society of Clinical Oncology, Oncology Nursing Society, and National Comprehensive Cancer Network. Advanced cancer treatment has been identified as a quality care indicator by the National Quality Forum and the Agency for Healthcare Research and Quality.

Implications for Practice

Nurses need to communicate with physicians about their knowledge of patients' wishes and any concerns that they have about goals of care. They need to seek the support of palliative care specialists for individual patients and reach out for help to resolve their own distress. Dilemmas may be prevented when well-functioning dialogue is present, as shown in the eight narratives described as lacking moral dilemma in Näppä et al.'s (2014) study. The opportunity for nurses to participate in decision making and discuss treatment goals with physicians, patients, and families can diminish ethical conflict. Nurses' participation can alleviate the tension between palliative care and cancer therapies through education, advocacy, and coordination of care.

Nancy G. Houlihan, MA, RN, AOCN®, is a nurse leader at Memorial Sloan Kettering Cancer Center in New York, NY. No financial relationships to disclose. Houlihan can be reached at houlihan@mskcc.org, with copy to editor at ONFEditor@ons.org.

Key words: palliative chemotherapy treatment; ethical conflict; nurses; moral dilemma

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