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Invited Commentary

LESS IS MORE

Talking to Patients About Cancer Screening Cessation

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There has been a growing realization that many individuals who have advanced illness or multiple medical conditions continue to receive cancer screening that is unlikely to benefit them. Such screening tests may also cause burden owing to the cascade of interventions that follows a positive test result and the burdens of the tests themselves. This has led to an important movement to stop unnecessary cancer screening by considering risks and benefits for individual patients and communicating effectively with the patient when the benefits no longer outweigh the risks.^{1,2} Screening guidelines are also beginning to consider when cancer screening should be individualized based on factors such as age, comorbidity, or life expectancy. Other guidelines note that evidence is insufficient to recommend a screening test for those older than a certain age.

Public health efforts to promote screening for cancer have been highly effective in raising awareness of its importance. However, the positive messages about screening from clinicians and the media may pose a major challenge to reducing rates of

unnecessary screening. Screening tests may also be prompted by form letters or postcards sent directly to a patient's home that may not be individualized based on factors such as advanced illness or age. Turning the tide on nonbeneficial testing will involve communicating effectively with patients and families to explain why, after years of hearing that screening is essential to health, the risks and benefits might have changed for the patient owing to advanced age or serious illness.

Prior research confirms that older adults view cancer screening very favorably and may even be suspicious of messages to stop.^{3,4} Unfortunately, there has been little evidence about aspects of communication that are effective and well received by patients when a screening test is no longer likely to be beneficial. The study by Schoenborn et al⁵ published in this issue of *JAMA Internal Medicine* provides important new information about what older adults do want to hear and situations in which they would consider cessation of cancer screening.⁵ The study found that many patients are amenable to stopping cancer screening in the context of a trusting relationship and when they hear messages addressing their own concerns, such as advancing age and declining health status.

These findings suggest a way to move forward in developing interventions that may resonate with adults with serious illness or advanced age who should reconsider the benefits of screening. These findings were based on a small sample of patients from 1 health system and are therefore only 1 important step in this research. Further work could develop and test messages based on these findings with larger groups of patients and could aid in the design of new interventions to reduce nonbeneficial screening.

Patients also reported that they would prefer to have discussions about screening cessation in the context of a trusting relationship, suggesting that communication would ideally take place in a longitudinal setting, such as primary care. This is challenging given the complexity of this communication. Primary care visits tend to be brief and must address many issues in patients with complex medical conditions. In such cases, one-on-one communication between the patient and clinician may be supported and augmented by decision aids that could be delivered in the primary care setting or even at home.

The present study by Schoenborn et al⁵ also provides evidence that most patients are resistant to messages that directly address their limited life expectancy. The growing field of prognosis has led to the availability of numerous instruments to determine life expectancy and strategies for communicating this information.⁶ Authors have advocated incorporating these measures into screening decisions. One prognosis scale has been incorporated into a decision aid for women considering whether to continue mammography screening.⁷ While this marriage of screening decisions and prognosis may seem logical, there has been inadequate data about how it is received by patients. The present study helps to inform this discussion by showing that messages that directly address individual life expectancy may not be well received by many older adults.

Why are patients resistant to hearing about life expectancy received in this context? It may be that it turns what would have previously been a discussion about maintaining health (“Let’s check for cancer to keep you healthy.”) into an unexpected discussion about the end of life (“You don’t need this colonoscopy because you have a greater than 50% chance

of death in the next 5 years.”). Such prognostic conversations are difficult even when patients are aware that they have a life-threatening disease such as cancer, but may be a shock in the primary care setting at a routine visit. As one participant said, hearing about such a prognosis might feel “like hitting you over the head with a hammer.”

This may leave clinicians in a challenging ethical position. Informed consent generally involves being transparent with our patients about our clinical reasoning. If I have a patient who has not had a mammogram in 2 years, I would consider whether to order another one. If the patient is 93 years old with chronic obstructive pulmonary disorder, diabetes, and severe osteoarthritis that limit her ability to care for herself independently, I might wonder if she would benefit from this test. To inform my decision, I might calculate her life expectancy using a prognostic index. I may conclude that this patient would not benefit from a mammogram because she will likely die in 4 or 5 years. Should I explain this to her? Or should I craft a message that focuses more on alternative treatments or quality of life because she will be more receptive to it, even if it is not how I arrived at my recommendation? Even in the setting of life-threatening disease, patients should always be given a choice about whether they hear numerical predictions about their own prognosis. Many may refuse this information and may even object to my use of it to make screening decisions.

Schoenborn et al⁵ found that messages about prognosis that are less direct may work better, such as “This test would not help you live longer.” Such language would allow the clinician to communicate about the use of prognostic tools without losing trust. Fortunately, their study also provides several alternatives that will address concerns that are also important to the patient, such as risks, burdens, and health status.

High-value care involves the right treatment for the right patient at the right time. Screening tests in the setting of other complex illnesses may lead to interventions that are poorly timed and do not help the patient. Despite the complexity of the task, the provision of quality medical care requires that we find effective approaches to address this complex issue with patients and their families.

ARTICLE INFORMATION

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