During her geriatric medicine fellowship in 2012, Nancy Schoenborn, MD, took notice of the American Geriatrics Society’s new guideline on caring for older adults with multimorbidity. Its advice for clinicians to incorporate prognosis into their clinical decision-making “really made a lot of sense to me…and it was supported by evidence,” said Schoenborn, an associate professor in the Division of Geriatric Medicine and Gerontology at the Johns Hopkins School of Medicine.

But when she considered how physicians should implement that advice, she didn’t have the words for it. Literally. “[I]t wasn’t clear how we should talk about it,” she said. The issue was particularly salient in cancer screening guidelines, which often use life expectancy of less than 10 years as the time to stop screening. Especially in primary care settings, where most cancer screening takes place, Schoenborn struggled with how physicians should tell healthy older patients they no longer need a mammogram, prostate-specific antigen test, or other routine cancer screening.

“If they pointed to the [guideline] and said, ‘Look, it says don’t screen if you have less than 10 years to live,’…that’s not going to go over very well,” she said. So Schoenborn went straight to the front lines. She and her colleagues interviewed older adults and primary care clinicians about how to discuss life expectancy in clinical decision-making and stopping cancer screening. In their most recent study, the investigators compared perspectives from both sides.

The study’s “good news is that there are several common themes that both the physicians and the patients agreed upon,” said Alexia Torke, MD, associate professor of medicine at the Indiana University School of Medicine, who has published research on cancer screening cessation. “That provides a good, brief framework for starting off this conversation,” added Torke, who wasn’t involved in the study.

Benefits vs Harms
Clinicians and older adults agree that talks about stopping cancer screening should include a discussion of the benefits and harms. “Every screening test has risks,” noted Elizabeth Eckstrom, MD, MPH, chief of geriatrics at the Oregon Health & Science University. “Mammography is a perfect example because there are so many false-positives. [W]ith colonoscopy…you could perforate the colon at a time when the person should never have had the procedure in the first place.”

When they’re armed with information about the pros and cons of screening, older adults in the study said the decision on whether to have the test should be their own. Clinicians agreed. Said one clinician who was interviewed: “I tell them that we are a team, so I explain the information and…then I leave it up to them.” But if older patients forgo screening, they also don’t want to feel that they’re receiving less care. “I would not want to just [stop screening] and then just not do anything else,” an older adult in the study said.

Perhaps the chief worry among clinicians was that by suggesting it’s time to stop cancer screenings, patients could become angry and feel their physician was giving up on them. “That was really a major concern and barrier” for clinicians, Schoenborn said. Added Eckstrom: “It’s a big deal emotionally for a lot of doctors.”

But older patients said they wouldn’t think badly of their physician for suggesting it’s time to stop screening. “They were actually not as reluctant as the doctors thought,” Schoenborn noted. “Many of them were willing, some had already stopped, and if they trusted their doctor it was not necessarily perceived as a negative thing.” In fact, patients in the study hoped clinicians would find that perception reassuring, she added.

Between a Rock and the Guidelines
The hurdle is talking about life expectancy with older adults. “When people go in for a routine checkup and you’re going to talk about whether they should get a mammogram or a colonoscopy, they’re not expecting a decision about how long they’re going
to live,” Torke said. “That’s something we need to consider if we’re even going to bring up that topic.”

In her study, Schoenborn said discussing life expectancy “did not really resonate with them...nobody liked that.” But when the subject was raised a little differently during the study—talking about ending cancer screening in terms of age, health status, and functional abilities—adults in the study were far more receptive. “Everyone thought that was a great idea,” she noted.

“So there was a disconnect in their perception between the inputs that we use to calculate life expectancy and the idea in the words of life expectancy itself,” Schoenborn said. “They didn’t really think about life expectancy as this conglomerate measure of their age, health, and function.”

That puts clinicians in a tough spot, she added. “They’re giving these guidances on what the ‘right thing to do’ is, but it’s in a language that they can’t just directly tell the patients very easily.”

Rather than use the guidelines’ blunt phrasing about life expectancy, clinicians can frame the message for older patients whose other health issues are of greater concern than cancer screening. For example, Eckstrom noted, explaining to an older woman that finding ways to help prevent her frequent falls is a priority over mammography.

Focusing on other health priorities “hopefully would give [clinicians] some place to start to have that conversation,” Schoenborn said. Eckstrom also has another strategy. “Sometimes I say, ‘You get to graduate from cancer screening; it’s a good thing. You don’t need this anymore,’” she explained. Some of her patients are relieved to learn they no longer need cancer screening tests. “Who wants another colonoscopy in their 80s?” she said.

But even if clinicians find the right words, institutional barriers can get in their way. Some insurance companies offer incentives for physicians to screen patients, but “they’re not putting upper age limits on it,” Eckstrom said. So instead of being made to feel their performance is subpar, physicians order the tests.

Automated computer systems in clinics and hospitals where physicians “have to click through a lot of things not to do something” also pose obstacles, Schoenborn said.

And then there are radiology departments that send routine reminders about mammograms, she added. So some patients who had decided to stop screening for breast cancer go in for a mammogram because a reminder told them they’re due.

The Flip Side of Success
Decades of public health messages have emphasized the importance of cancer screening. “We have these very clear, consistent messages that sit on the side of a [mailbox] or on a billboard: get your colonoscopy,” Torke said.

Clinicians and patients get into the routine of regular screening, and advocacy groups sport pink ribbons to encourage mammograms. “There is a lot of emotional attachment to doing that,” Schoenborn said. “It’s part of being a good citizen.”

But the time may be ripe for a “more public health approach to raise awareness in the public that stopping screening can be the right thing,” she added. “Maybe a first step is just to raise awareness that it’s not something we all have to do until we die.”

Note: Source references are available through embedded hyperlinks in the article text online.