Although exchanging hope for acceptance may not be clinically valuable, nonacceptance is clearly linked with suffering, which clinicians are charged with relieving. Acceptance may be associated with a higher quality of life in patients with a terminal illness.

“We’ve begun to accumulate a body of literature that suggests that patients who have more cognitive awareness of their terminal prognosis are less depressed,” says William S. Breitbart, MD, vice chair of the Department of Psychiatry and Behavioral Sciences, and chief of the Psychiatry Service at Memorial Sloan–Kettering Cancer Center.

“This last study [by Thompson, et al] is another piece of evidence showing that if [clinicians] are able get someone gently to be more aware of their prognosis, to accept it with some sense of peace and equanimity, that there can be better outcomes in terms of patient quality of life, timely completion of advance directives, and the course of bereavement in family members,” he adds.

Another option that has been shown in previous studies to be an effective therapy for terminally ill patients is something called dignity therapy. Dignity therapy is a concept that has been developed and promulgated by one of Dr. Thompson’s coauthors, Harvey M. Chochinov, MD, PhD, of the Department of Psychiatry at the University of Manitoba.

“Loss of dignity for people with advanced cancer is associated with high levels of psychological and spiritual distress and the loss of the will to live. Dignity therapy is a brief psychotherapy, which has been developed to help promote dignity and reduce distress,” Dr. Chochinov and his colleagues write. Dignity therapy was touted by Dr. Breitbart and others as a potential treatment option in depressed or anxious patients with a terminal prognosis.

Another option is to treat the symptoms of nonacceptance, anxiety, and depression pharmacologically. “We do prescribe antidepressants for people who are terminally ill and depressed,” Dr. Breitbart explains. “We tend to prescribe drugs that work a little more quickly than conventional antidepressants, drugs like Ritalin or amphetamines that work in days rather than weeks. It’s very common.”

Dissenting Opinion

Not all clinicians agree with the foregoing interpretations of these findings. “I’ve certainly seen people who denied dying up to their last breath and somehow never accepted it,” Dr. Holland tells CA. “Were they more upset? I’m not sure.”

She cautioned against allowing the findings by Dr. Thompson and colleagues to set a tone in which nonaccepting patients are viewed as dysfunctional. Death is as individualized as is life, she argues, invoking Sir William Osler, who said “Basically, people die as they have lived.”

She suggested that Dr. Thompson and her colleagues had identified “a subgroup that had been maladaptive all along,” meaning that patients who were anxious or depressed after a terminal prognosis were likely anxious or depressed before the prognosis.

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New Joint Outpatient Chemotherapy Administration Standards

The Oncology Nursing Society (ONS) and the American Society of Clinical Oncology (ASCO) have released a set of joint standards for the safe administration of chemotherapy in the adult outpatient setting. The standards, published in the journals of both societies (Oncol Nurs Forum. 2009;36:651–658 and J Clin Oncol. 2009;27:5469–5475), are intended to improve patient safety, reduce the risk of medication errors, increase clinical efficiency, and provide a framework for best practices.

The guidelines were created largely in response to recent studies that have examined reports of chemotherapy administration errors among outpatients, and to reports of an increased risk of errors with the administration of new oral chemotherapeutics.

The ASCO/ONS recommendations call for “standardized approaches, development of policies and procedures for system improvement, and review of errors by interdisciplinary professional staff,” the authors write. The steering group also recommends the increased use of electronic medical record systems, such as E-prescribing. Research has shown that automated systems can reduce errors and increase patient safety.

The Standards

[The standards] “were developed to help reduce the risk of errors in chemotherapy administration, thereby assuring patient safety.” says Terri Ades, DrNP, a member of the steering committee that developed the standards and director of Cancer Information and Health Promotions at the American Cancer Society.
The article comprises a total of 31 standards that run the gamut of oncology practice in this setting, ranging from staffing-related standards to those covering chemotherapy monitoring and error reporting. Examples include standards for chart documentation, chemotherapy orders, drug preparation, and patient consent and education.

The consent and education standard directly addresses patient safety issues as they relate to oral chemotherapeutics. It is intended to ensure that “patients and caregivers receive information that they can understand,” and are fully involved in the therapeutic process, Dr. Ades notes.

The consensus document lays out clear guidelines for nearly every aspect of chemotherapy administration to outpatients, concluding with one for error reporting. “The practice has a process for risk-free reporting of errors or near misses. Error and near miss reports are reviewed and evaluated at least semiannually.”

**Filling a Standards Vacuum**

The risk of errors during the administration of chemotherapy has increased as the number of regimens expands and the use of oral chemotherapeutics becomes more common. Despite the increasing risk of errors, there are few national standards for safe administration.

“This is probably the best and most complete interdisciplinary set of safety standards for chemotherapy and oral antineoplastics. Nothing else has been so far reaching and has involved the whole [oncology] community,” says Robert Dreicer, MD, chairman of the Department of Solid Tumor Oncology at the Cleveland Clinic and professor of medicine at the Cleveland Clinic Lerner College of Medicine in Cleveland, Ohio. Dr. Dreicer adds that baseline criteria for safe practice “has for many years been left in a vacuum.”

The societies had also recognized this vacuum. “We identified through various means, including questions we get from ASCO members, that there aren’t clear standards out there for chemotherapy administration,” explains Kristen McNiff, MPH, director of the Quality Division in the Department of Cancer Policy and Clinical Affairs at ASCO, and one of the authors of the standards document.

**Oral Chemotherapeutics**

Another factor that has increased the need for broad-based interdisciplinary standards has been the development of oral chemotherapeutic agents. The steering group cited these drugs as posing new, specific safety challenges. For example, adherence is difficult to monitor, and poor adherence has been reported to negatively affect the safety and success of chemotherapy.

“The one thing that I would point out that is more important than the set of guidelines is that it’s reflective of the dramatic increase in oral antineoplastic drugs,” Dr. Dreicer says. “These safety standards speak to that. It’s more reflective of current practices.”

According to the National Comprehensive Cancer Network task force on the safety of oral chemotherapeutics, safety challenges with these drugs stem from a lack of oversight of administration, an increased risk of patient noncompliance, and a lack of monitoring techniques (J Natl Compr Canc Netw. 2008;6[Suppl 3]:S1-S14). The new standards directly address these challenges.

**Compliance**

Although compliance will be voluntary, there is some concern over the degree to which members of the oncology community will adopt the new safety standards. To help with the adoption of these standards, ASCO is using the Quality in Oncology Practice Initiative (QOPI) as a vehicle. ASCO has selected 17 of the 31 safety standards for initial implementation as part of a new practice certification program that was launched in January 2010 as a new component of QOPI. “Practices will need to meet a variety of different components, one being meeting scoring requirements on chart data that are submitted during the regular QOPI analysis program,” Ms. McNiff explains.

Both ASCO and ONS are using multiple strategies to increase awareness of the new standards. “We’re trying to make sure that we’re getting the word out as much as possible and ONS is doing the same thing to make sure that our members know that these standards exist and the members can use them for their own internal processes,” Ms. McNiff adds.