Older Adults May Not Consider Life Expectancy an Important Factor in Cancer Screening

Although clinical guidelines for cancer screening generally incorporate life expectancy into the balance between benefits and harms among older individuals, a recent study has found that many older adults may not consider life expectancy to be relevant to their decisions regarding screening (JAMA Intern Med. 2017;177:1121-1128). The study authors identified alternative approaches to communication that are better suited to aligning screening decisions in this population with clinical evidence.

“A study like this one is a timely addition on how to handle difficult conversations and represents an important step to overcome barriers,” says Corinne Leach, PhD, MS, MPH, strategic director of the Cancer and Aging Research department at the Behavioral Research Center of the American Cancer Society, who was not affiliated with this study.

Study Methodology
Nancy Schoenborn, MD, assistant professor of geriatric medicine at Johns Hopkins University in Baltimore, Maryland, and colleagues recorded semistructured interviews with 40 community-dwelling, English-speaking adults aged older than 65 years (mean age, 76 years) who demonstrated a wide range with regard to health status, functional status, and life expectancies, including participants from ambulatory clinics and home-bound settings.

Before the interviews, the investigators spoke with each participant about the benefits and harms of screening for breast, prostate, and colorectal cancers. In these discussions, the investigators explained that it often takes 10 years before a new cancer grows enough to cause health problems, and therefore patients whose life expectancy is less than 10 years may experience the short-term harms of screening without the longer-term benefits that result from the detection and treatment of less advanced cancers.

Questions for participants centered on 2 domains: 1) decision making regarding whether to continue or stop screening and patient reactions to provider recommendations to stop screening; and 2) communication preferences regarding strategies for discussing screening cessation that cover the risks and benefits of screening, age, health status, and life expectancy. Information regarding the participants’ demographic characteristics, health status, functional status,

KEY POINTS
- Although many elderly individuals considered their age and health status to be relevant in making decisions regarding cancer screening, they often did not understand the role of life expectancy.
- It is important for providers to incorporate patient preference into communication strategies regarding cancer screening.
- In the context of good physician-patient relationships, discussions regarding discontinuing cancer screening generally do not negatively affect older adults’ views of their physicians.
health literacy, and level of trust in their clinicians also was collected. Of the 40 participants, 23 (57.5%) were female and 25 (62.5%) were white. The estimated life expectancy was less than 10 years for 19 participants (47.5%). All participants reported high levels of trust (4.7 of 5.0) in their clinicians.

Results and Clinical Implications

Three key themes were identified in the study. First, participants with high levels of trust in their clinicians generally were open to stopping cancer screening. Second, although many participants agreed to consider their age and health status in their decisions concerning cancer screening tests, there was some confusion regarding the relevance of life expectancy. Third, the majority of participants preferred that clinicians frame recommendations to stop screening based on age or health status rather than life expectancy. Specific verbalization regarding life expectancy such as, “you may not live long enough to benefit from this test” was considered to be too harsh. Instead, participants preferred a more positive message such as, “this test would not help you live longer.”

Comments from some study participants demonstrated an understanding of the need to balance the benefits and harms of screening (eg, “If I would get cancer I would not want anything done as far as a procedure to cure it and that’s when I made my decision [to stop screening].”). Other participants focused more on their trust in their clinicians (“If a doctor of his caliber suggests, ‘let’s not be hasty, we probably won’t have to do this [prostate-specific antigen test],’ then I was very willing to say don’t worry about it now.”).

The authors recognized the limitations of their study, including its self-report format, which may be subject to “recall bias” and “social desirability bias,” as well as the fact that because the study was conducted within an academic medical center setting in which participants had regular visits with their physicians, its generalizability to patients without an ongoing patient-physician relationship remains uncertain.

However, a major strength of the study was its testing of the role of communication in future screening recommendations. Dr. Schoenborn notes that the study also indicated that trust was very important in the physician-patient relationship. “For those older adults who trusted their clinicians, a recommendation from the clinician to stop screening did not negatively affect their views of the clinicians, even if they disagreed with the recommendation and want to continue screening,” she says.

doi: 10.3322/caac.21414