

# Contribution of Collegial Support Meetings (CSM) in the management of complex situations of patients with advanced cancer

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## Research Article

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# Abstract

## Purpose

Collegial Support Meetings (CSM) have been set up in the Gustave Roussy Cancer hospital for inpatients whose complex care requires a multi-professional approach involving participants from various fields. CSMs are composed not only of oncologists but also of health-caregivers, a member of the palliative care team, an intensivist and a psychologist. This study aims to describe the role of a newly implemented CSM in a French Comprehensive Cancer Center.

## Methods

Each week, the health-caregivers decide the situations to be examined, depending on the difficulty of a clinical case and/or the occurrence of specific events. The discussion goes on to include the goal of treatment, grading the level of care, ethical and psychosocial issues, and the patient's life plan. The patient's wishes are carefully considered. Finally, to obtain feedback from the teams, a survey has been distributed to the health-caregivers to assess the interest in the CSM.

## Results

In 2020, 114 inpatients were involved: 84 patients were metastatic and had received a median of 2 lines of treatment. Their general condition was deteriorated: 50% of patients were entirely dependent on care. During the CSMs, 55% of the discussions focused on whether to continue specific cancer treatment - 29% were about whether to continue invasive medical care - 50% about optimizing supportive care. Forty patients (35%) died during the hospitalization.

## Conclusions

CSM, an innovative approach in French oncology, places health-caregivers at the heart of the system and strives to reach consensual and consistent conclusions for all medical and nursing staff involved.

## Introduction

Due to progresses in oncology more treatment options are available so that metastatic cancers which often used to be fatal, are now compatible with prolonged survival. However, the quality of life, which is sometimes affected by treatments and by the fact that patients are living longer, may raise questions about practice. As a result, the importance of supportive care is increasingly emerging early on, at the point when advanced situations begin to be managed. Indeed, the complex needs of patients with advanced cancer arise many months before the patient's death [1]. The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families [...] by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"[2]. Some complex management situations require specific support and decision-making assistance, which must be organized and carried out through multi-professional

meetings. However, we are observing a worrying paradox in oncology: while a collegial approach is usually proposed at the beginning of the disease (where clinical situations are less complex and framed by strong scientific recommendations), this collegiality disappears as the course of the disease becomes more complex with relapses and metastases, thus making the oncologist increasingly isolated in decision-making.

For that reason, in 2014, the 3rd National Cancer Act [3, 4] recommended developing formalized cross-disciplinary-meetings for complex cases, in addition to the traditional Multidisciplinary Meetings (MDM) [5]. In the light of these recommendations, our French Cancer Center found an ideal way to continue its efforts to develop a palliative culture and to improve the inclusion of palliative medicine into the cancer care continuum. In 2015 the Ethics Committee and the Supportive Care Department at Gustave Roussy set up the Collegial Support Meetings (CSMs) aimed to promote thoughts and recommendations on how advanced cancer is managed and to help redefine the goals of care according to a patient's clinical status. Here we present the procedure that was implemented in our Comprehensive Cancer Centre and discuss the place of palliative care not only in the context of oncology but also in relation to wider challenges facing the public health care system in providing access to palliative care.

## **Patients And Methods**

### **Objectives**

The aim of this study was to explain the contribution of CSMs in the management of complex situations for inpatients at the advanced stage of their disease and to assess health-caregivers' interest in CSMs.

### **Study design**

This prospective and consecutive cohort study was conducted over a period of 13 months at Gustave Roussy Comprehensive Cancer Center in France. Clinical and biological data of cancer patients who were presented to the CSMs were prospectively collected in four departments (three units of the Medical Oncology Department and the Department of Therapeutic Innovation and Early Trials [DITEP]). We also completed data retrospectively in order to retrieve discharge information about our patients (place of discharge, possible date of death, date of the last chemotherapy in relation to date of death...).

In order to complete the assessment of the organization, we developed a survey for the health-caregivers of the units involved in the CSM in order to obtain their qualitative assessments of these meetings. The responses to the items were intended to shed light on three points: the opinions of the health-caregivers on the contribution of the CSMs in the therapeutic decisions and the prescription of supportive care; the feelings of each health-caregiver with regard to his or her place in the CSMs and finally, the possibilities for improvement in order to optimize them.

# Description of the CSM

The CSMs comprise oncologists but also other professionals (nurses, nursing staff, etc.), a member of the palliative care team (PCT), an intensivist and a psychologist. These meetings are intended for inpatients whose complex care requires a multi-professional and multidisciplinary approach. The discussion also includes questions such as treatment objectives, grading the level of care, ethical and psychosocial issues and the patient's life plan and it may provide additional opinions for the MDMs, sometimes reorienting their decisions. The CSMs are currently held weekly for one hour in the four units mentioned above. The situations examined are proposed by the health-caregivers themselves, in relation to difficulties in care and/or the occurrence of particular events during hospitalization. The wishes of the patients (expressed directly, or by advance directives) are a cornerstone of the discussion about the goals of care.

The main problems discussed during the CSMs are classified into 4 categories: 1. the intensity of the oncological treatments; 2. the therapeutic commitment in case of worsening clinical status (resuscitation, surgery, etc.); 3, the optimization of supportive care; 4, the future orientation of the patient. In addition, relational difficulties between the patients and their relatives or with the care team are also addressed. Limitation or cessation of active treatment and the decision taken in advance to transfer to the intensive care unit (ICU) in the event of worsening are also sometimes discussed. In addition patients' outcomes are also examined in the light of the criteria provided by the Decision-Aid Form (DAF), completed by the referral oncologist, which our center has been using since 2015 and which contains an estimated grading of care if the patient's conditions deteriorate [6]. The four degrees of planned stratification of care in case of an acute event are discussed during CSM.

At the end of the CSM a collegial recommendation is proposed and a report is included in the patient's electronic medical record.

## Statistical analysis

Analysis was performed on all enrolled patients. Quantitative data were summarized using number of observations with interquartile range. Qualitative data were summarized using number of observations and proportion by modality. Proportions were compared univariately using a Fisher exact test. Survival comparisons were performed using a Log-rank test. This study was reviewed and approved by the Gustave Roussy Scientific Commission (Institutional Review Board), which did not identify any unethical elements.

## Results

### Clinical analysis

Over a 13 months period, between January 2, 2020 and February 2, 2021, 2263 patients were hospitalized in the 4 units concerned. The hospital mortality rate among these 2263 patients was 11.5% during the study period.

The cases of 114 patients were discussed (median age, 51.6). One third had gastrointestinal cancer. The patients were essentially at an advanced stage of the disease: 91% had metastatic disease and had received a median of 2 lines of specific oncologic treatment (Table 1).

Table 1  
**Characteristics of patients** *Data are expressed as n (%), rounded up to the nearest decimal place), median [IQR]*

| <b>Variables</b>                | <b>n = 114 (%)</b> |
|---------------------------------|--------------------|
| <b>Demographic data</b>         | <b>64 (56.1)</b>   |
| Female                          | <b>54 [15.6]</b>   |
| Age, years                      |                    |
| <b>Oncology data</b>            |                    |
| Tumor type                      | <b>39 (34)</b>     |
| Gastro-intestinal               | <b>17 (14)</b>     |
| Lung                            | <b>15 (13)</b>     |
| Sarcoma                         | <b>12 (10)</b>     |
| Gynecological                   | <b>8 (7)</b>       |
| Breast                          | <b>6 (5)</b>       |
| Dermatological                  | <b>5 (4)</b>       |
| Urological                      | <b>4 (3.5)</b>     |
| Brain                           | <b>7 (5.7)</b>     |
| Others                          |                    |
| Therapeutic goal                | <b>8 (7)</b>       |
| Curative care                   | <b>81 (71)</b>     |
| Palliative chemotherapy         | <b>6 (5.3)</b>     |
| Palliative with clinical trial  | <b>19 (16.7)</b>   |
| Palliative care only            |                    |
| Metastases                      | <b>10 (8.8)</b>    |
| No                              | <b>27 (23.7)</b>   |
| One metastatic site             | <b>77 (67.5)</b>   |
| Pluri-metastatic                | <b>2 [2]</b>       |
| Lines of Chemotherapy           | <b>8 [35.6]</b>    |
| Last chemotherapy, days         |                    |
| <b>General state</b>            |                    |
| Performance Status at inclusion | <b>10 (8.8)</b>    |

| <b>Variables</b>               | <b>n = 114 (%)</b> |
|--------------------------------|--------------------|
| 1                              | <b>18 (15.8)</b>   |
| 2                              | <b>40 (35.1)</b>   |
| 3                              | <b>46 (40.3)</b>   |
| 4                              | <b>41 (36)</b>     |
| LDH $\geq$ 1,5N                | <b>65 (57)</b>     |
| Albumin < 33mg/l               | <b>57 (50)</b>     |
| Not self-sufficient at all     |                    |
| <b>Reason for admission</b>    | <b>27 (23.6)</b>   |
| Specific oncological treatment | <b>4 (3.5)</b>     |
| Treatment-related toxicity     | <b>67 (58.7)</b>   |
| Disease-related symptoms       | <b>16 (14.0)</b>   |
| Sepsis                         |                    |

A look at the participation rates of the various stakeholders shows that the medical and paramedical teams of the hospitalization unit (oncologists, nurses, and nursing assistants) were always present. A member of the PCT was also nearly always in attendance. The intensivist and a psychologist were present for 102 and 103 cases respectively (90%). Finally, the participation rate of the referring oncologist was 24.5% (Table 2).

Table 2  
Stakeholder participation rates

| <b>Participation rates</b> | <b>(%)</b> |
|----------------------------|------------|
| Oncologist                 | 100        |
| Palliative care Doctor     | 100        |
| Psychologist               | 90.3       |
| Intensive care Doctor      | 89.4       |
| Nurses/caregivers          | 100        |
| Chief nurse                | 59.6       |
| Attending oncologist       | 24.5       |

During the CSM, four main topics (Table 3) were discussed. First the intensity of the oncological treatments was discussed in more than one half of the cases presented. Overall, exclusive palliative care



was decided in 60% of these cases. In the remaining patients, continuation consisted most often of chemotherapy with dose reduction or a less toxic regimen, resumption of oral therapy to control symptoms, or exit from a phase 1 protocol with resumption of standard chemotherapy.

Secondly a discussion of medical commitment/invasive procedure occurred in about one third of patients leading in more than half to decisions to limit treatment.

Then optimization of supportive care was the second most frequent concern, mainly with regard to psychological management. It should be noted that the PCT was already involved *before* the CSM in only 22% of the presented cases. During 6 CSMs (5.3%), a continuous deep sedation until death (CDSUD) [7] was discussed (requested by the patient or their family). This decision was finally made for only one patient at his/her own request. In the other cases, effective anxiolysis or proportionate sedation were sufficient to provide relief.

Finally, the orientation of the patient after the current hospitalization was discussed in 57 of the 114 patients. Almost two thirds of patients were discharged alive, but most needed Hospice care or Hospital at Home (HaH); only less than 20% simply returned home.

Table 3  
**Issues discussed in CSM** *Data are expressed as n (% , rounded up to the nearest decimal place), median [IQR]*

|   | No. (%)          |
|---|------------------|
| <b>1) Oncology decision making</b>                            | <b>51 (44.7)</b> |
| <b>NO because :</b>   | <b>27 (23.6)</b> |
| Continuation of treatment already decided                     | 24 (21.1)        |
| Exclusive palliative care already decided                     | 63 (55.3)        |
| <b>YES :</b>  | <b>19 (16.7)</b> |
| Continuation of treatment                                     | 44 (38.6)        |
| Validation of treatment discontinuation                       |                  |
| <b>2) Discussion of medical commitment/invasive procedure</b> | <b>81 (71.1)</b> |
| <b>NO</b>   | <b>33 (28.9)</b> |
| <b>YES :</b>  | <b>19 (16.6)</b> |
| No Intensive Resuscitation - surgery - transfer to ICU        | 1 (0.9)          |
| Continuation of the Extra Renal Purification                  | 13 (11.4)        |
| IR or surgery or resuscitation if needed                      |                  |
| <b>3) Optimization of supportive care</b>                     | <b>57 (50)</b>   |
| Pain management   | 11 (9.6)         |
| Management of refractory occlusive syndrome                   | 7 (6.1)          |
| Psychological or psychiatric management                       | 33 (28.9)        |
| Discussion of complex patient/family/team relationship        | 12 (14.5)        |
| Discussion of continuous deep sedation until death (CDSUD)    | 6 (5.3)          |
| Social measures to be put in place                            | 8 (7)            |
| Patients known by the PCT before the CSM                      | 25 (22)          |

|  |                  |
|--|------------------|
| <b>4) Hospital outcome and orientation of patients</b> | <b>74 (64.9)</b> |
| Patients discharged alive                              | 24 (21)          |
| Kind of discharge:                                     | 9 (7.9)          |
| Hospice care   | 8 (7.0)          |
| Inpatient rehabilitation facility                      | 11 (9.6)         |
| Palliative care at home                                | 20 (17.5)        |
| Hospital at home                                       | 2 (1.8)          |
| Home   | 40 (35.1)        |
| Transfer to a medical care unit                        |                  |
| Death during this hospitalization                      |                  |

The impact of the CSM on subsequent decisions was assessed only semi-quantitatively by a retrospective reading of the charts. Based whether or not there were data mentioning therapeutic changes, decisions to transfer or a new level in the ADF, within the few days following the meeting, we estimate that between 65 and 75% of CSMs influenced further decisions.

Among 35% deaths occurred during the hospitalization where the CSM was held. The time relapsed between last chemotherapy and death was 24 days [IQR, 28.5], and the time between CSM and death was 7 days [IQR, 5]. On April 30, 2021, three fourths (n = 86) of the patients were dead.

When the outcomes of the patients were compared to the stratification indicated in the DAF (about 80% of them were classified as non-invasive or exclusively comfort care), the gradation was significantly correlated with survival, with a Log-rank P value < 0.0001 (Fig. 1).

## Exclusive Palliative Care (EPC)

### Survey for the health-caregivers

Of the ninety health-caregivers who were questioned, seventy (50% nurses, managers and coordinating nurses; 36% senior physicians and residents; and 14% nurse-assistants) responded to the survey (Fig. 2). Feedback was quite positive. Regarding the health-caregivers' perception of the contribution of the CSMs to therapeutic decisions (continuation or not of an oncological treatment, performance of an invasive procedure), 61% agreed or strongly agreed that the CSMs could help decide on the specific oncological project; 80% agreed or strongly agreed that the CSMs could help decide on the intensity of medical management. Also, 78% agreed or strongly agreed that the CSMs allowed the involvement of support care teams such as the psychologist, the mobile PCT, and the social worker. Moreover, the experience of the CSMs was judged to be satisfactory. The teams felt comfortable: 90% of the teams felt that it was a

place for free discussion and 74% felt that it was a place for listening; 76% of participants did not feel uncomfortable. Overall, the CSMs were well received since 80% of the teams find these meetings useful. The presence of the attending oncologist was requested by 84% of the participants. In addition, when the open-ended question was asked, "What changes could be made to make the CSMs more useful?" the participation of the referring oncologist was requested 12 times.

## Discussion

To our knowledge, the present study is the first one to show that a multi-disciplinary approach may be usefully integrated into the clinical course of patients with complex and advanced disease in a French oncology setting. Such a strategy is an important element of an overall institutional policy to improve the integration of palliative care in patient care. This is also in accordance with international recommendations of the last decades [8–10]. Several observations may be made in the light of our experience.

Through decision making and collegial discussion, the CSMs try to lead to a progressive improvement in patient care. However, it seems necessary to introduce palliative care earlier and to reduce the prescription of chemotherapy in the advanced palliative phase, with the help of tools such as the DAF, but also with the presence of the referring oncologist at the CSM. As far as the team is concerned, the interaction and complementarity of the various players contributes to a feeling of satisfaction with the team experience.

The attending oncologist is often absent in spite of the fact that their involvement in these end-of-life and palliative care issues is important and necessary [11], as his/her long-standing relationship with the patient can provide important insights into the patient's experience of the disease and treatments, and sometimes can help explain why a patient wants treatment or invasive procedures.

An ICU physician also participates in the CSMs. Indeed, in an emergency situation, the intensivist may not be familiar with the oncological prognosis which adds to the prognosis of acute failure. However, studies show that anticipating a critical situation and interdisciplinary discussion contribute to a better selection of patients who will benefit from intensive care, with the aim of reducing mortality and improving use of resources [12]. This is one of the missions of the CSMs, to try, through anticipation and collaboration between the intensivist and the oncology team, to determine the best indication for a patient's transfer to the ICU if the situation arises, and this was possible for 90% of the CSMs.

The most important thing is not to be "too late" in referring cancer patients to PC specialists, a fact which has long been demonstrated and which is recommended by academic societies. In this regard, Temel et al. showed that early PC consultation offered to patients diagnosed with advanced non-small cell lung cancer improved both anxiety and depression, quality of life and overall survival [13]. Their study marked a turning point for the integration of PC into cancer care and stressed how valuable it is to introduce the PCT early on. It proved that the systematic integration of palliative care at the time of advanced cancer

diagnosis is both feasible and helpful without worsening patients' anxiety or depression, in the specific population of non-small cell cancer patients [14]. In subsequent studies, early and systematic palliative care which focused on symptom management, psychosocial support, and assistance with decision making, was found to have similar results in patients with other solid cancers. These later studies showed that early introduction of PC leads to a higher quality of patient care at a lower cost for patients with advanced cancer, improving their quality of life, managing psychophysical symptoms, and reducing the use of medical services at the end-of-life [15–18]. Moreover, ASCO has always recommended that treatment not be given unless there is a definable benefit [19]. In a retrospective study of patients with lung cancer who survived at least 3 months from the time of diagnosis, patients who received chemotherapy within 2 weeks of their death did not survive longer than those whose chemotherapy was discontinued earlier [20]. In situations in which further chemotherapy is almost certain to be futile, treatment should be directed at symptom palliation and psychological support.

A lack of anticipation often leads to unwarranted ICU transfers and excessive emergency admissions, and may result in unsatisfactory communication between health-caregivers and poor information transfer to patients and their families [21]. Conversely, early discussions about the goals of end-of-life care are associated with improved patient and family outcomes, including better quality of life, reduced use of non-beneficial medical care near death, and treatment that is more consistent with patients' wishes [22–26].

However, while palliative care is now generally being recommended early in the course of advanced cancer [27–29], it is often proposed too late and only after the withdrawal of cancer treatments [30–32] with the result that it has a low impact on patients' quality of life [33]. The reasons for this delay are now well known and multiple [22, 30, 34, 35]. Patients and family barriers to early referral often include a negative image of palliative care and unwillingness to stop anti-cancer treatments. Barriers related to medical staff often include delayed discontinuation of anti-cancer treatment (therapeutic advances enhance the belief among oncologists that they can always provide effective treatment), insufficient awareness of palliative care, inaccurate prognosis assessment and inadequate communication skills to discuss poor prognosis. The way care is organized also contributes to this delay, since PCT intervention is usually based on the presence of uncontrolled psychophysical symptoms or specific situations that raise ethical questions, such as death requests. In our cohort, only 25 patients (22%) had already met the PCT before hospitalization. This late intervention of palliative care is a concern in both French and international settings.

The situation in France is particularly worrisome. Despite numerous laws since 1999 and several “plans for palliative care”[36], both PC units and PC teams remain understaffed in our country. About one quarter of French regions don't have a single PC unit. Between 100,000 and 200,000 people need access to palliative care every year [37]. The national budget for PC is about 2.5 euros per person (compared to 5 times more in our Belgian neighbors). Despite the lack of units, teams and money, a large anticipating and palliative culture should at least be more present in the routine practice, especially in the setting of chronic and severe illnesses such as cancer. For this reason, between 2018 and 2020 we put all our

efforts into developing a major institutional program to integrate oncology with palliative care. CSMs are a significant part of this program, additionally to the development of advance care planning and the promotion of end-of-life discussions. The present study shows that a multidisciplinary approach in patients with advanced cancer is feasible, suitable, and virtuous, but also that there is a long road ahead. Perspectives for future progress include a greater involvement of attending oncologists in this multidisciplinary approach, whose input may be needed to make effective decisions. On the other hand, an earlier and stronger involvement of patients and proxies themselves in the decision-making process is certainly a promising pathway forward.

This observational study has several limitations. First neither emergency room, surgery nor hematology patients were included (although we consider that CSMs should be implemented in most of these settings). Above all, only 5% of hospitalized patients were discussed, with a very high short-term mortality rate (one third of patients included, while the hospital mortality rate was 11.5% in these units): this may represent a bias of under-selection of patients eligible for CSM discussions. Finally, the impact of the CSMs on subsequent decisions and outcomes was only assessed retrospectively. On the other hand, some strengths should be noted: all patients presented in CSM were prospectively identified and consecutively included during a 13-mo period; data collection (CP, FB) and analysis methodology were homogeneous; short and mid-term analyses were performed.

## Conclusion

Cancer therapeutics are improving and creating new levels of prognostic uncertainty for patients and oncologists. In addition, more generally, ageing has become a major challenge and patients are presenting with a growing number of comorbidities. Therefore, voluntarist public health policies are needed to deal with peoples' increasing vulnerabilities. In oncology, continued research on early interventions and value-focused communication strategies are needed to overcome the difficulties of implementing advanced care planning into clinical practice. As distinct from MDMs, which only involve physicians, CSMs place the health-caregivers at the heart of the system and strive to reach consensual and consistent conclusions for all medical and nursing staff involved. This suggests that addressing the quality of collaboration and the structure of discussions is necessary in order to integrate PC into oncology. Moreover, such structured collaboration can easily be organized in oncology settings and adjusted to patients' disease trajectories and to innovations in cancer therapy.

## Declarations

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- **Ethical Approval:** This study was reviewed and approved by the Gustave Roussy Scientific Commission (Institutional Review Board), which did not identify any unethical elements

- **Competing interests:** The authors have no relevant financial or non-financial interests to disclose.

- **Authors' contributions**

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- Administrative support : Sarah DAUCHY, Sarah DUMONT, Florian SCOTTE
- Collection and assembly of data: Caroline POISSON, Francois BLOT, Jamila MARDAGHI
- Data analysis and interpretation: Caroline POISSON, Francois BLOT,
- Manuscript writing: All authors.
- Final approval of manuscript: All authors

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## Figures

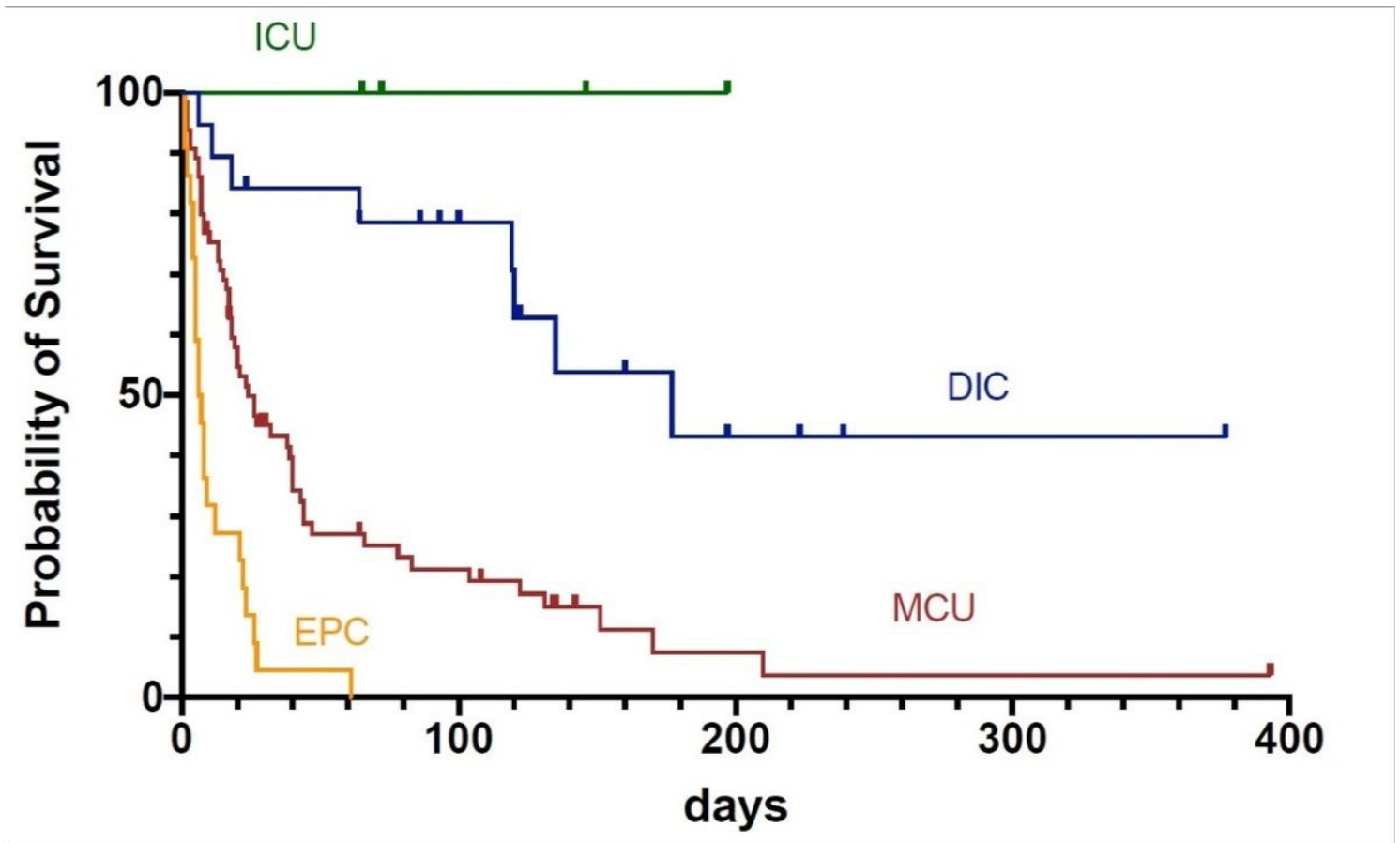


Figure 1

Survival curves according to the Decision-Aid Form (ADF)

*Intensive Care Unit (ICU) (IC whatever the problem is)*

*To Discuss IC admission (DIC) (IC if the problem can be quickly resolved)*

*Medical Care in Unit (MCU) (Non-Invasive care, without CPR, intubation...)*

*Exclusive Palliative Care (EPC)*

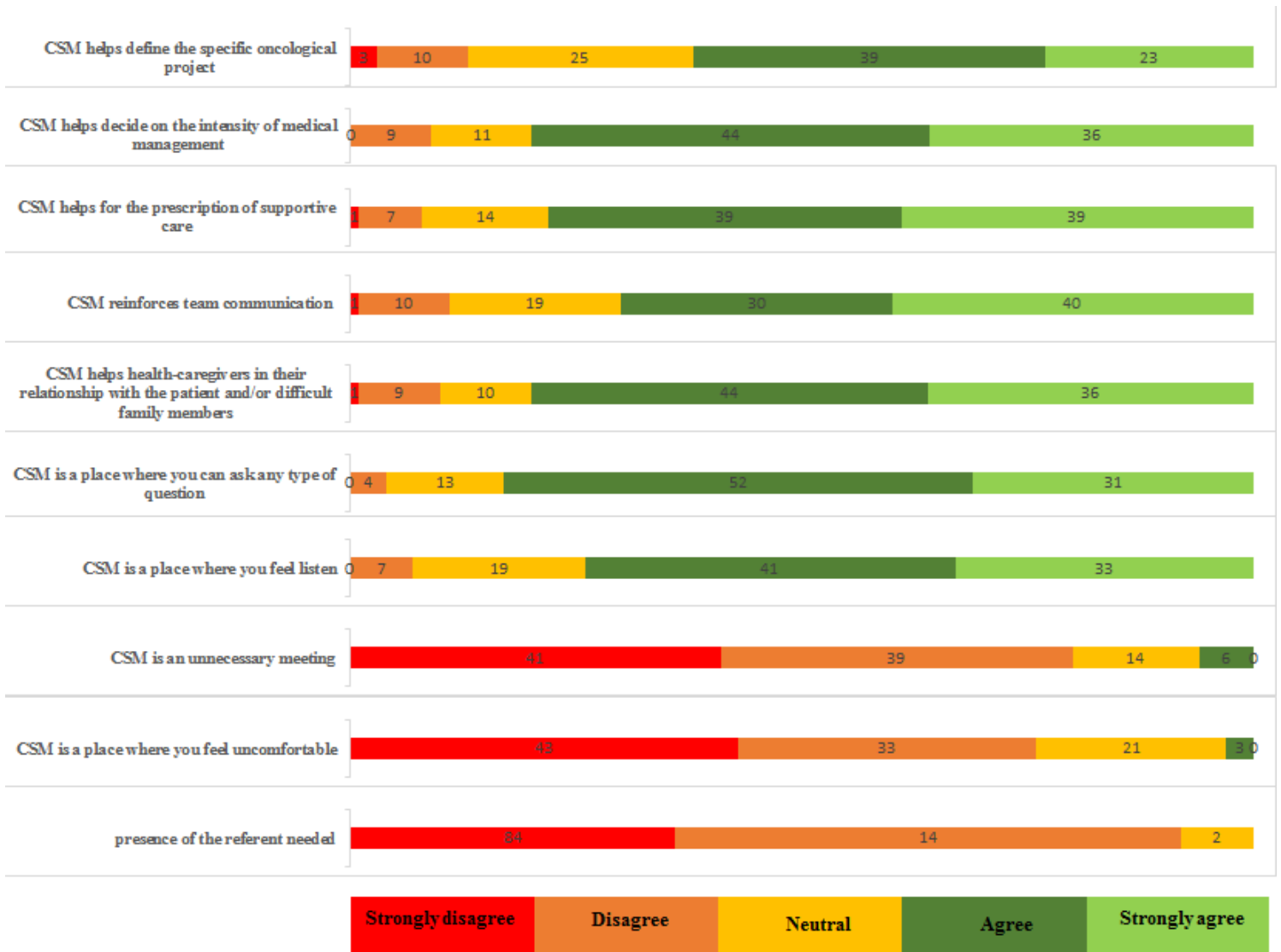


Figure 2

Results from the Survey