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Cécile Fraux, Maria Teresa Munoz Sastre

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# Mapping people's Attitudes to Life-prolonging Treatments

Cécile FRAUX & Maria Teresa MUNOZ SASTRE  
CERPPS  
Université de Toulouse, France

## INTRODUCTION

End-of-life conditions of patients in terminally-ill condition are always difficult to define. There are a variety of factors to consider, specifically concerning the end-of-life patients suffering from an incurable disease. It is essential to distinguish concepts which aims to stop or limit actives therapeutics: 1) euthanasia: intension to administrate a lethal dose of drug, with the consent of the patient in terminally-ill condition. 2) Rejection of care: patient's possibility and right to refuse treatment. 3) Therapeutic abandon: complete cessation of all treatments (curative and palliative). 4) Cessation of treatment: stop or limit life-prolonging treatment. In France, euthanasia is forbidden. Nevertheless, recent the Léonetti law gives the right to passive euthanasia (or cessation of treatment) (Légifrance, 2005). Some patients are offered more or less aggressive treatments that may prolong their life for sometimes. These treatments can often have undesirable side effects. The main issues of this kind of decision lay in the quality of life patient, in others words the benefits of treatment need to be higher than the risks (Bruchon-Schweitzer & Boujut, 2014; Brédart & Dolbeault, 2004). Ethically, doctors have to stop the pointless or disproportionate treatments (Desmedt, 2004). A lot of studies look at the acceptable end-of-life conditions of terminally-ill patients (Mullet et al., 2014; Van Wijmen, Pasman, Widdershoven & Onwuteaka-Philipsen, 2015). The acceptability of ending a patient's life depends of different circumstances. The psychological consequences are often found as the major impact when considering the end-of-life procedures (Frileux, Munoz Sastre, Antonini, Mullet & Sorum, 2004; Lhermite, 2014). Beyond the cognitive changes, the pain increases this decision (Guedj et al., 2005). In context of incurable disease, life prolonging treatments need to be considering with the side effects to preserve the dignity of the patient. To study the acceptability of life-prolonging treatment among French laypeople, we used the Information Integration Theory (Anderson, 1981) measuring different ethical positions.

## METHODS

### **PARTICIPANTS**

103 participants (M=54, 07; SD=21,20)  
61 women (M=54,19; SD=21,60) and 42 men (M=53,90 ; SD=20,88)

### **MATERIAL**

-Questionnaire of personal characteristics  
-Questionnaire of 36 scenarios, were composed of all combinations of four factors potentially impacting the judgment of acceptability of the prolongation-of-life treatments

#### *Number of months of life prolongation (3 modalities)*

- 6 months
- 12 months
- 18 months

#### *Physical consequences of the treatment (2 modalities)*

- Undesirable side effects are fully controlled
- Treatment is painful with pains, nausea, vomiting and negative consequences

#### *Psychological consequences (2 modalities)*

- Patient keeps contact with reality
- Patient loses contact with reality

#### *The amount of time spent at the hospital (3 modalities)*

- Patient don't spend much time in the hospital
- Patient spends half of his time in the hospital
- Patient is always at the hospital

### **EXAMPLE OF SCENARIO**

Mrs. Roberday is 71 years-old. She has just been diagnosed with a rare type of cancer. A treatment exists but this one will extend Mrs. Roberday's life expectancy of approximately six months only.

This treatment cannot be done at home. The patient must be hospitalized most of the time. The treatment is painful because it can cause pains, nausea, vomiting and other inconveniences.

This treatment also damages the good mental functioning of the patient mind. At some stage, the patient loses contact with reality.

If there is no treatment, the pain which appears gradually is controlled, and during the terminal phase, palliative cares are set up.

*If you were Mrs. Roberday, to what extent you would agree to start such a treatment?*  
NO, certainly o---o---o---o---o---o---o---o---o---o YES, certainly

## RESULTS

### **PROCEDURE**

2 phases during 30 to 40 minutes

#### *-Familiarisation phase*

1/3 of scenario are randomly presented to the participant, he can ask questions and go back on his answers

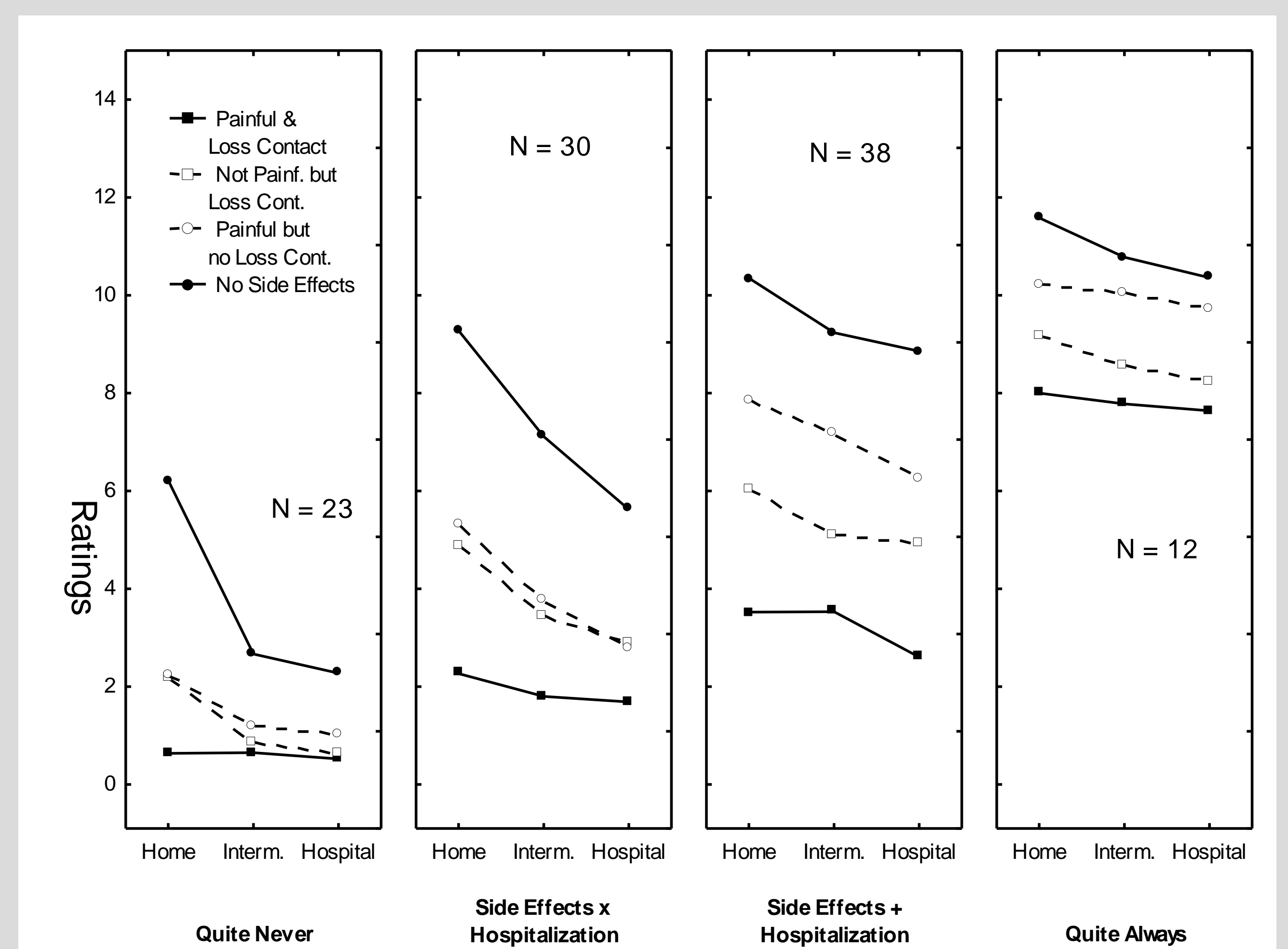
#### *-Experimentation phase*

The 36 scenario are randomly presented to the participant, he has no possibility to ask questions nor go back on his judgments

### **RESULTS**

Cluster analysis allowed clearing different groups of policy of judgment:

-Four clusters were found. They were called Quite Never Agree (N = 23), Depends Interactively on Severity of Side Effects and Length of Hospitalization (N = 30), Depends Above all on Severity of Side Effects (N = 38), and Quite Always Agree (N =12).



## DISCUSSION

- People considerably differ regarding attitude to life-prolonging treatment. When side effects (pain and loss of contact with reality) are not too severe, most people agree to start medical treatment. When side effects are severe, however, only a minority of people agree to start treatment. In addition, about a quarter of people would not necessarily agree to start life-prolonging treatment, even if side effects were fully controlled.

- Whether the medical treatment was expected to prolong life six months or eighteen months had, surprisingly, not much importance, compared to other factors. As stated by some people, living an additional 18 months without much contact with of reality and in a painful state is not really living.

- In practical terms, asking patients whether they agree to start life prolonging treatment implies to fully explain the consequences of treatment. As the severity of side effects are largely patient-dependent, determining them on an individual basis is, unfortunately, not always feasible.