Advance Care Planning Among Cancer Patients - The Kenyan Situation

Advance Care Planning (ACP) is an iterative process through which adults at any stage of health engage in discussions with their healthcare givers that aid in understanding their values, goals and preferences for future medical care and thus align healthcare provision with these goals and preferences (1). The process may lead to the completion of advance directives which are legal documents in which one outlines their wishes for future medical care and take effect once a patient loses their decision making capacity. Advance directives can be updated with changing health status and can be withdrawn or reviewed at any point in the spectrum of care (1).

Implementation of advance care planning confers benefits not only to the patient but to the healthcare system and to the family. Key among these is the potential to reduce the cost of end of life care and mitigate against provision of futile yet expensive treatments at the end of life such as mechanical ventilation in the setting of metastatic cancer. Advance directives ease the decisional burden that next of kin usually bear during end of life care thus reducing stress and anxiety faced by these persons (2).

The concept of ACP has gained traction in the field of palliative care in the past three decades. The implementation of the Patient Self Determination Act in the United States in 1991 set the framework for widespread education initiatives and a call to implement ACP in the population at large (3). Globally, developed nations have followed suit with countries like Australia, Germany, Spain, Israel and Netherlands implementing laws to facilitate uptake of ACP (4–7). The same cannot be said of Africa where there is paucity of data on ACP and no national laws exist on ACP. The situation in Kenya is reminiscent of the African situation with no national laws currently governing the practice of ACP (8). Where practiced, this is done under institutional policy. The Kenya Palliative Care Policy 2021-2030 highlighted the need to create a legal framework to set the stage for ACP and AD implementation as a key priority area and this is a welcome move (9).

According to GLOBOCAN 2020 data, cancer ranks as the third leading cause of death in Kenya with 42,116 new cases and 27,092 deaths (10). Most cancer patients in our set up present with advanced disease (11). Cancer cases are projected to rise by 120% in the next two decades. Cancer care has been identified as a high priority area by the Ministry of Health with efforts directed towards prevention through vaccination, screening and early detection of cases as well as treatment being supported by government (12). ACP may further improve the quality of cancer care by inculcating patient values and goals for care into treatment planning. The National Palliative Care policy 2013 outlines advance care planning discussion as the standard of care in palliative care thus implementation in the cancer population is warranted (13).

There is paucity of data on the practice of ACP among cancer patients in our setup. A recent dissertation study by Lavender *et al* (2022, unpublished) at the Kenyatta National Hospital found that the uptake of advance directives among ambulatory cancer patients was less than 30% with a low rate of completion of living wills (1.5%). This was the first study on the uptake of advance directives among cancer patients in Kenya. It was noted that ambulatory cancer patients were receptive to the idea of having ACP discussions facilitated by their doctors and held a positive view of nearly all domains of ACP including discussions of end of life wishes with doctors and family and discussions around life expectancy. Similar to observations made by other studies in the developed world, cancer patients preferred to have ACP discussions initiated as soon as cancer diagnosis was made. This dispels the fear that ACP discussions may cause patients to lose hope and forms a basis for early engagement in the ACP process regardless of cancer stage (14).

Aside from the legal ramifications of ACP, the role of culture in our setting cannot be overlooked. ACP discussions entail end of life discussions and in the African setting, discussions on death are frequently frowned upon. The belief in life after death, religious beliefs and the patriarchal structure of our society are key aspects to be considered as we plan ACP practices in our set up. It has been observed that despite widespread education initiatives and a relatively high uptake of advance directives among white Americans, African Americans have lagged behind on the completion of advance directives (15). Qualitative studies from the US among African Americans have identified sociocultural and religious aspects as key players in this low uptake (16). It is therefore important to have further studies examining these aspects in order to design more culturally sensitive ACP practices that would aid in realizing the stated benefits.

Regardless of the huge knowledge gap on the possible confounders that may negatively impact the practice of ACP in our set up, it is relevant in our low resource setting. A qualitative study conducted in South Africa noted that ACP was relevant in the African context including formalizing these discussions through advance directives (17). Retrospective data from a private tertiary facility in Kenya among terminally ill patients noted that the advance directives completion rate was 41.2% (8). This implies that where

practiced under a policy framework and standardized processes, good outcomes can be realized.

There remains a huge knowledge gap on ACP and AD in Kenya and its practice in the field of oncology. Studies examining both patients and healthcare givers may provide insight that will aid in bettering implementation of ACP in a low resource set up. National and institutional policies that aid in standardization of the process remain high priority areas.

Otom LGA, Department of Clinical Medicine and Therapeutics, Faculty of Health Sciences, University of Nairobi, P.O. Box 19676-00202, Nairobi, Kenya. Email: lavenderotom@gmail.com

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