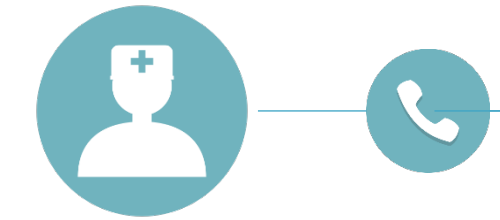
LTC+ Virtual Care Support for Long-Term Care Homes in Ontario

Facing Decline and Death in the Time of COVID: Conversations with Geriatric and Palliative Care

LTC+ is a collaboration between Women's Virtual at Women's College Hospital, GEMINI at Unity Health Toronto, the Ontario General Medicine Quality Improvement Network, the Centre for Quality Improvement and Patient Safety and the Department of Medicine at the University of Toronto

Agenda

- LTC+ Program Update
- Role of Advanced Practice Virtual Care Nurses
- When to Consult Geriatrics – Dr. Camilla Wong
- Palliative Care Integration During COVID-19 in LTC – Dr. Warren Lewin
- Q&A: Ask the Experts



Attending MD in LTC can access…

Press 1 to reach…

General Internal Medicine On-Call (24/7)

- Access to urgent medical consultations and advice

Press 2 to reach…

Advance Practice Virtual Care Nurse (9-5)

- Rapid needs assessment, advice, and linkage to services

- **GERIATRICS**
- **PALLIATIVE CARE**
- Behavioural Supports
- Wound Care
- GeriMedRisk
- Neurology

Enhanced Point of Care Services and Care Pathways

- Mobile Diagnostic Imaging (STL Imaging)
- Access to STAT labs through LifeLabs

LTC+ Program Overview

LTC+ Advanced Practice Virtual Care Nurse

Melanie Henry, RN, BScN, MPH, IIWCC
Women's College Hospital

Holly Rector, DNP, NP-Adult
Women's College Hospital

LTC+ Virtual Care Support for Long-Term Care Homes in Ontario

Melanie Henry

Holly Rector

LTC+ Virtual Care Support for Long-Term Care Homes in Ontario

In addition to connecting you with subspecialty consult services we can also provide:

1. Support nursing staff with virtual assessment, problem solving, and care planning for LTC residents

2. Connect LTC physicians and staff with community resources and coordinate services to promote safe and quality care for residents

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When to Consult Geriatrics

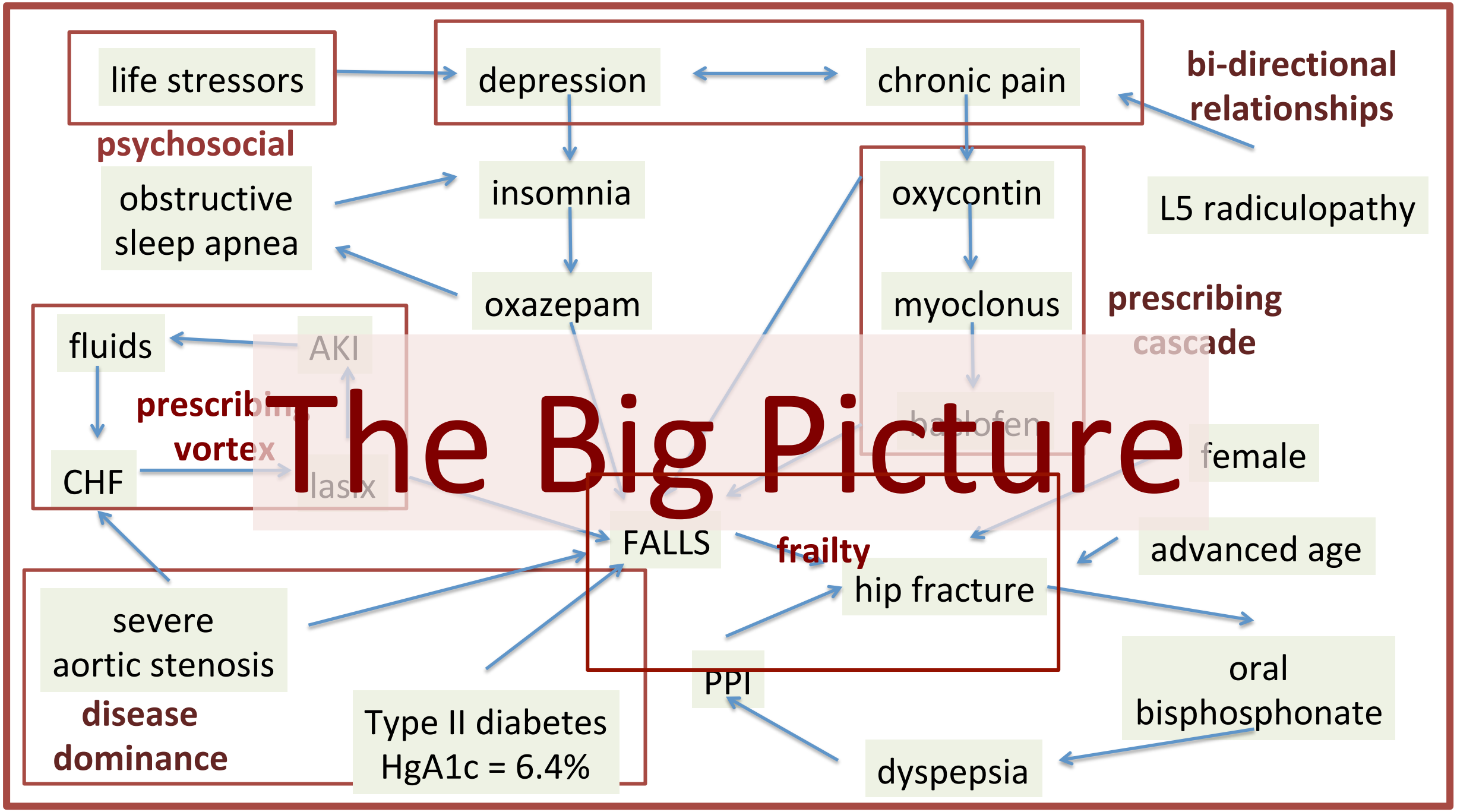
Camilla Wong, MD, MHSc, FRCPC
Geriatrician, Unity Health Toronto
Associate Professor, Department of Medicine, University of Toronto

"I don't know where to begin."

"I have a bad feeling ..."

"I just need another set of eyes to make sure what we are doing makes sense."

"The usual medical management is not feasible."



The Big Picture

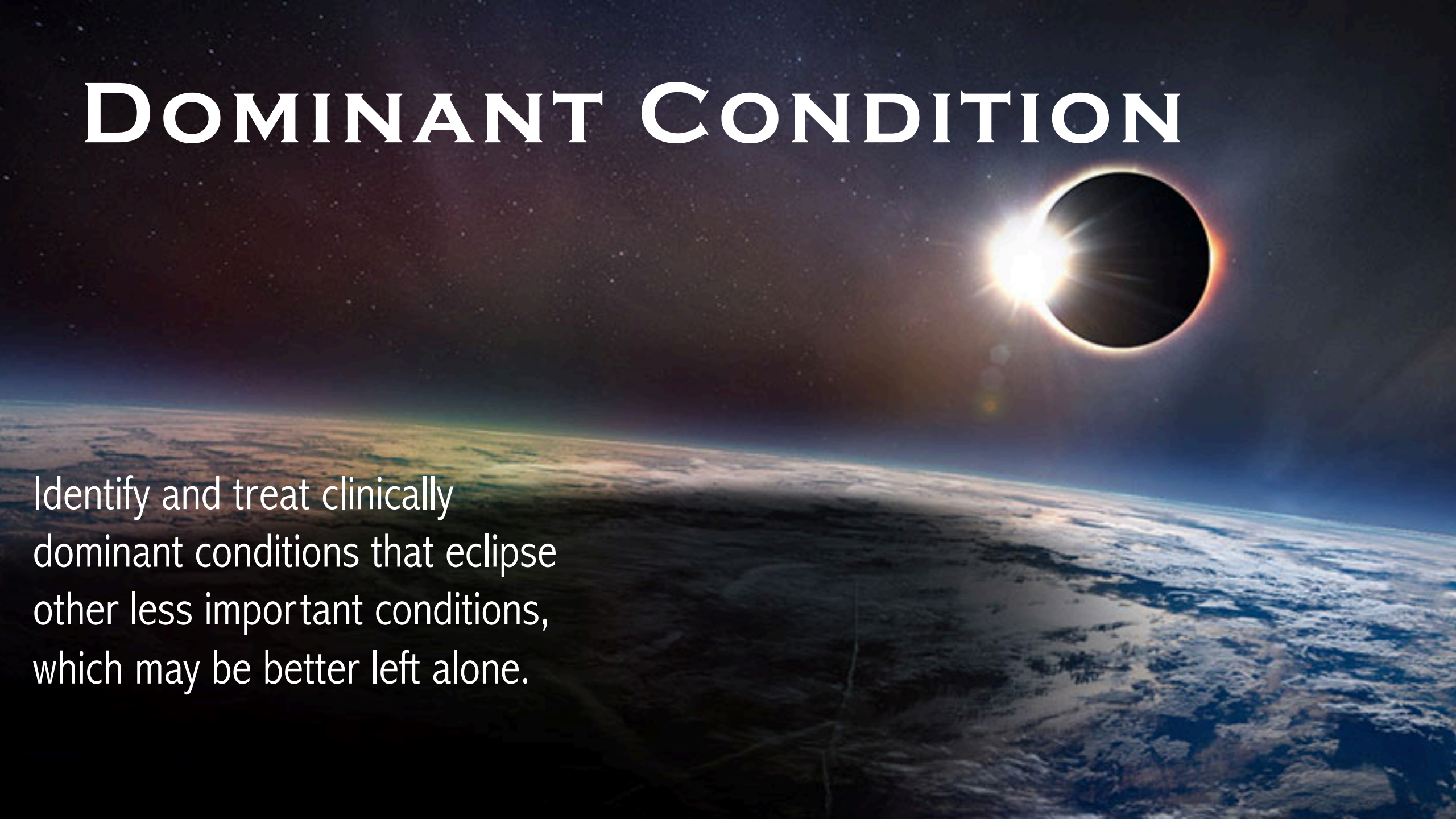
Concordant Conditions

Similar pathophysiologic profile and disease management plans.

Discordant Conditions

Not directly related in either pathogenesis or management.

Dominant Condition



Identify and treat clinically dominant conditions that eclipse other less important conditions, which may be better left alone.

NNT

Number Needed to Treat
number of patients who need to be treated to prevent one outcome

NNH

Number Needed to Harm
number of patients who need to be exposed to incur one adverse event

TIME TO BENEFIT (TTB)

The time until a statistically significant benefit is observed in trials of people taking a therapy compared to a control group not taking the therapy.


WHAT MATTERS
TO YOU?
Moving from
“What is the
matter?”

THERAPEUTIC HARMONIZATION

Aligning goals and prognosis with care.

Medicine

Identification

Past Medical History

Medications

History of Present Illness

Review of Systems

Physical Examination

Investigations

Differential Diagnosis

Management

Medicine

Identification
Past Medical History
Medications
History of Present Illness
Review of Systems
Physical Examination
Investigations
Differential Diagnosis
Management

Geriatric Medicine

Identification with Frailty Level
Past Medical History
Medications
History of Present Illness
Geriatric Review of Systems (cognition, mood, nutrition, mobility, skin, sensory, sleep, pain, abuse, continence)
Functional History (Impact on ADLs, IADLs)
Social History
Mental Status Examination
Physical Examination
Investigations
Differential Diagnosis
Prioritization of Management

Medicine

Identification
Past Medical History
Medications
History of Present Illness
Review of Systems
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Differential Diagnosis
Management

Geriatric Medicine

Identification **with Frailty Level**
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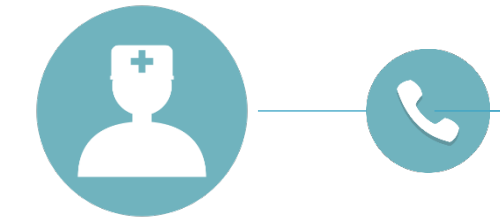

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LTC+ Program Overview

Triage to Geriatric Medicine for

- frailty
- delirium (acute change in cognition / mental status)
- falls
- transitions in care (recent discharge from acute care)
- polypharmacy
- multimorbidity
- functional decline
- weight loss
- constipation
- incontinence
- Parkinson's or parkinsonism
- caregiver stress
- elder abuse

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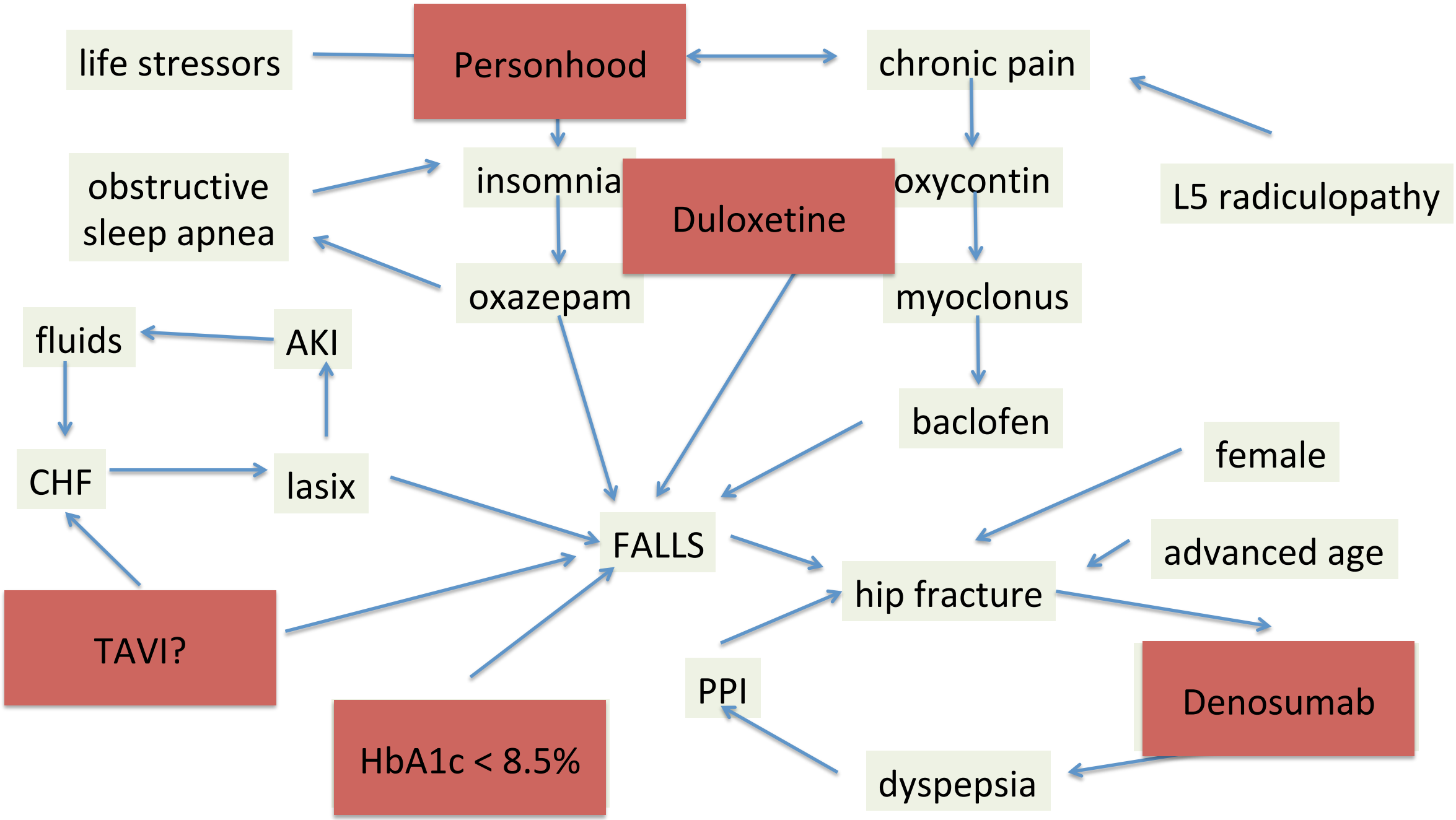
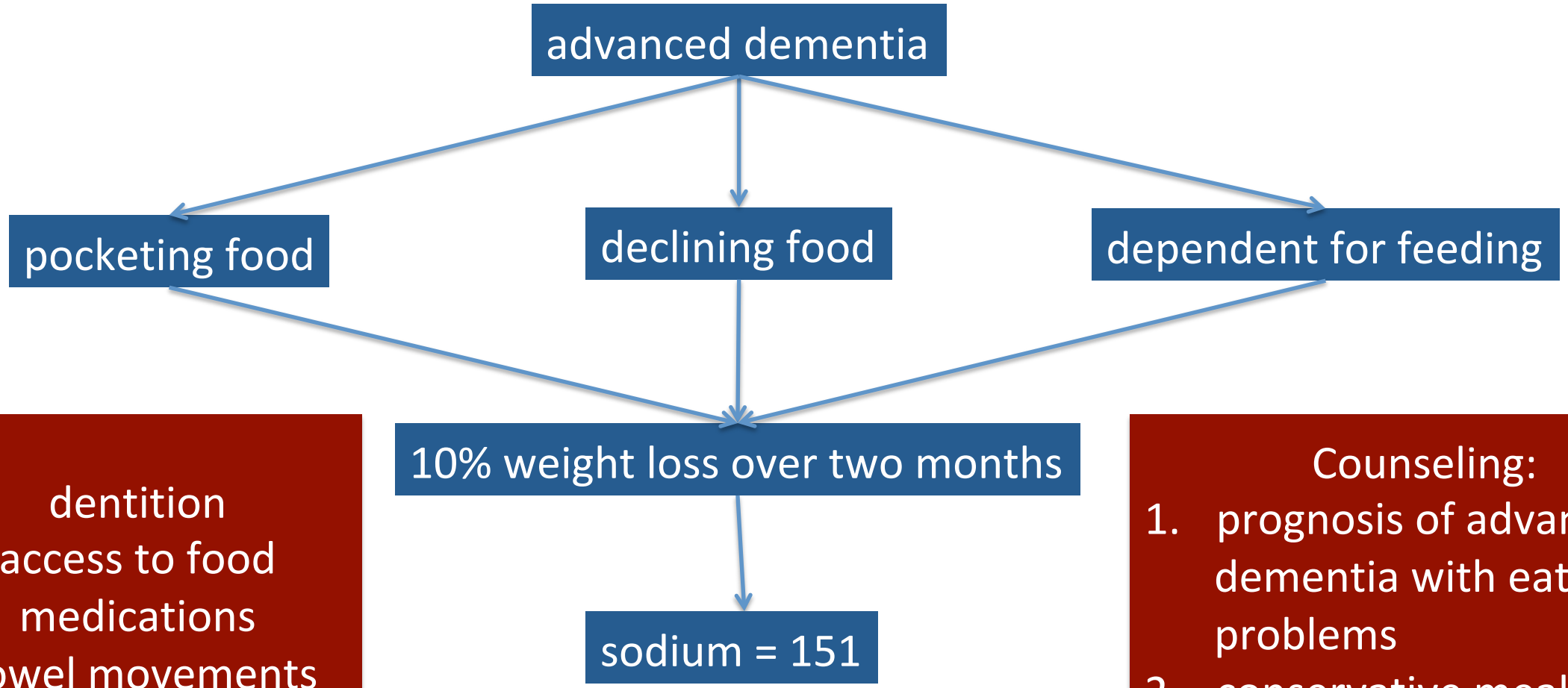
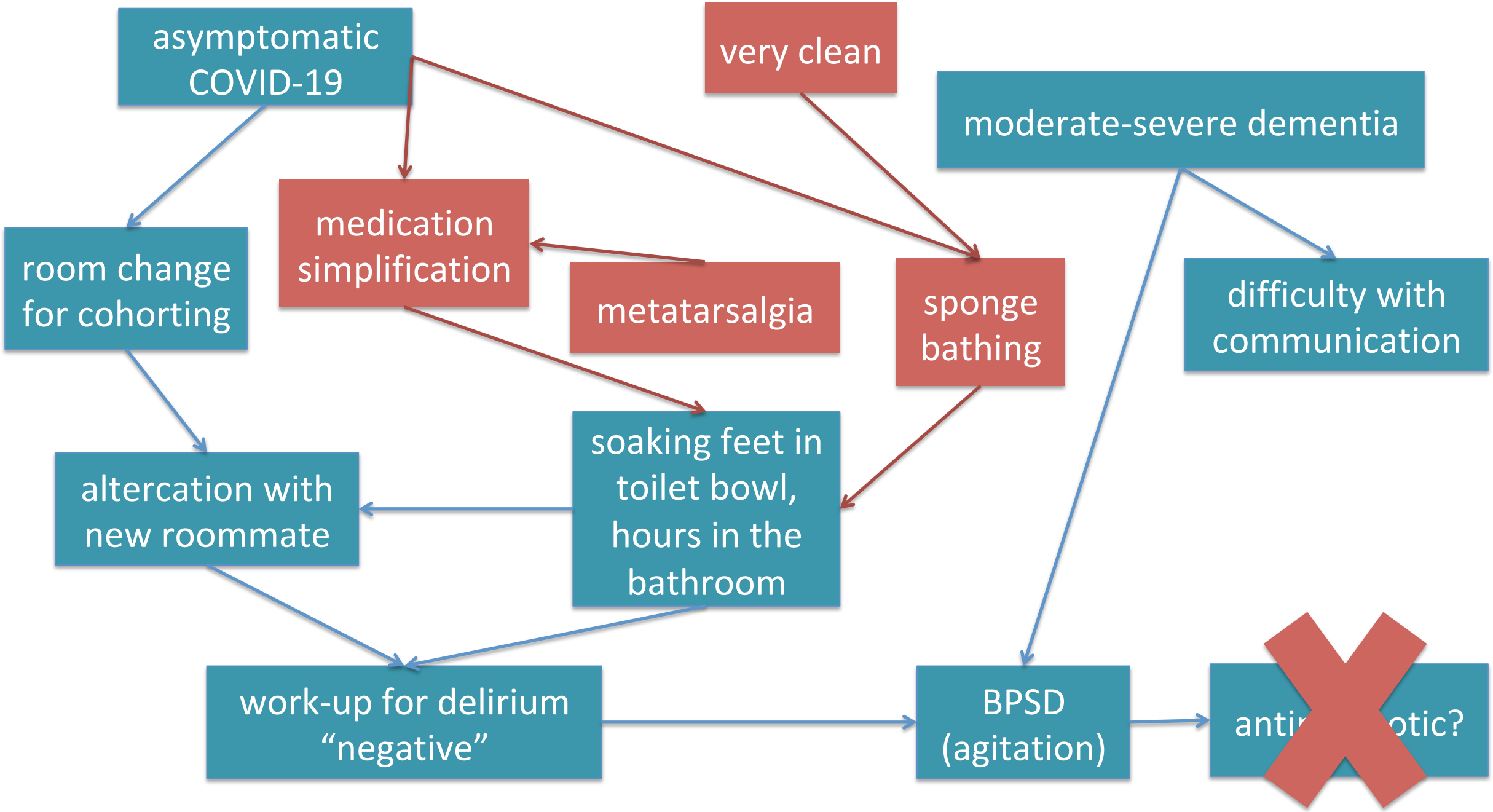

life stressors
Personhood
chronic pain
L5 radiculopathy
obstructive sleep apnea
insomnia
Duloxetine
oxycontin
oxazepam
myoclonus
fluids
AKI
baclofen
CHF
lasix
female
FALLS
advanced age
hip fracture
TAVI?
PPI
Denosumab
HbA1c < 8.5%
dyspepsia

"I have a bad feeling ..."


advanced dementia
pocketing food
declining food
dependent for feeding
10% weight loss over two months
sodium = 151
dentition
access to food
medications
bowel movements
mood
pain
food preferences
Counseling:
1. prognosis of advanced dementia with eating problems
2. conservative meal time approaches
3. supplementation
4. hand vs. tube feeding

"I just need another set of eyes to make sure what we are doing makes sense."


asymptomatic COVID-19
very clean
moderate-severe dementia
room change for cohorting
medication simplification
metatarsalgia
sponge bathing
difficulty with communication
altercation with new roommate
soaking feet in toilet bowl, hours in the bathroom
work-up for delirium "negative"
BPSD (agitation)
otic?

”The usual medical management is not feasible."

Parkinson’s disease: Sinemet 100/25 q3h	Add Entacapone
CHF: Fluid restrict to 1.2 L	Chase the weight by adjusting Lasix
Diabetes: Basal-bolus insulin	Detemir, with frailty-based goals

When and why a geriatrics referral is helpful

- frailty
- delirium
- falls
- transitions in care
- polypharmacy
- multimorbidity
- functional decline
- weight loss
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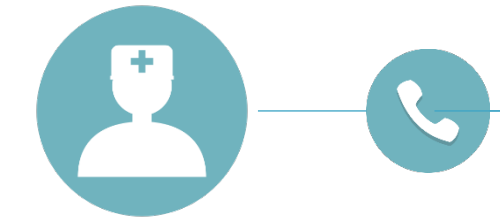

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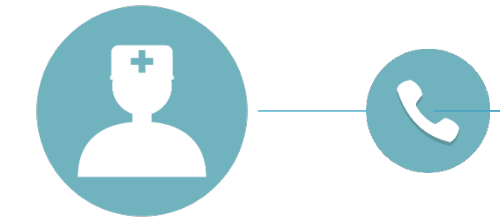
LTC+ Program Overview

Palliative Care Integration During COVID-19 in LTC

Warren Lewin, MD, CCFP
Toronto Western Hospital, University Health Network
Assistant Professor, Department of Family and Community Medicine, Division of Palliative Care, University of Toronto



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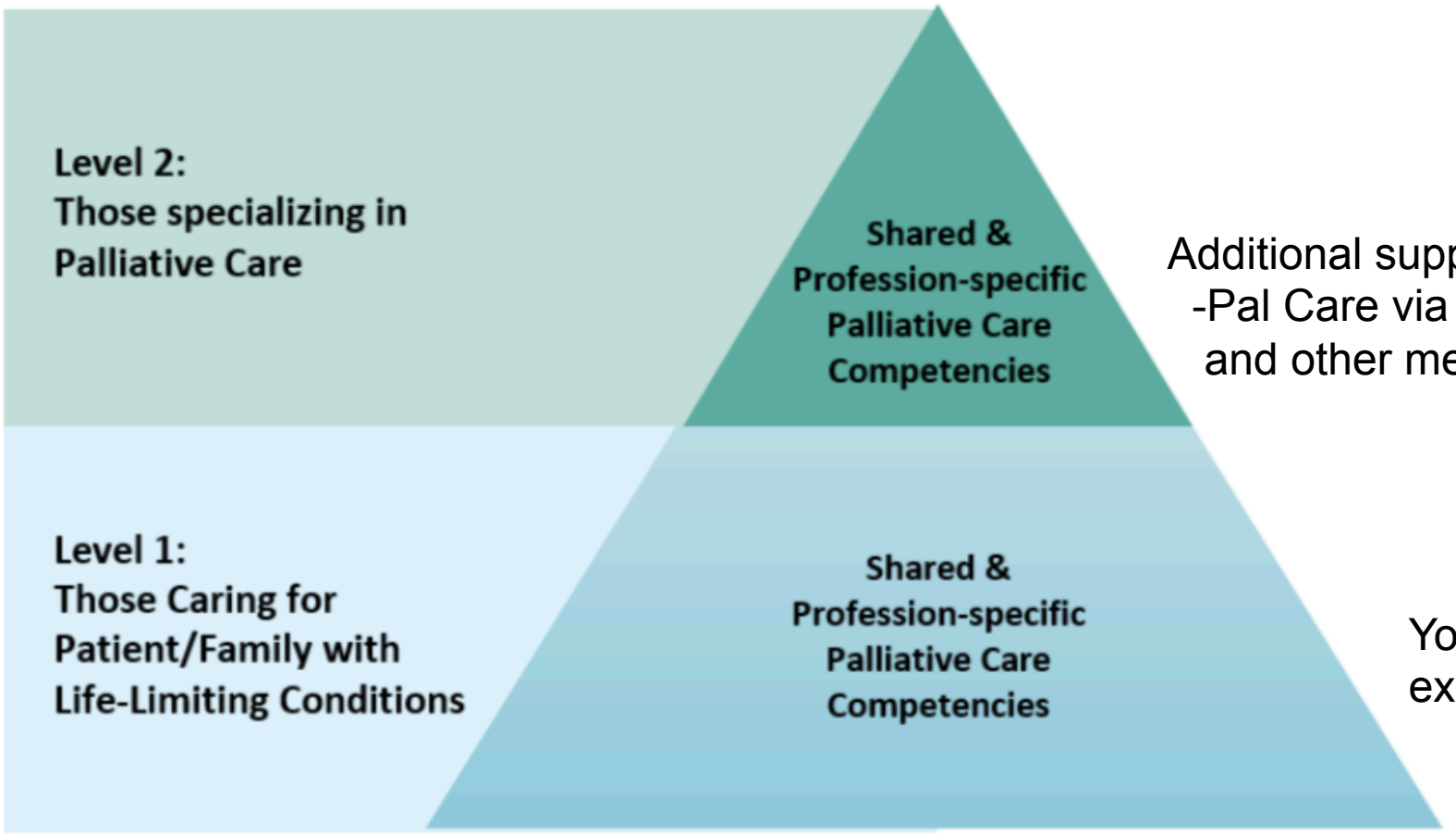
Palliative Care Integration During COVID-19 in LTC

Bulk of Palliative Care Provided by You



Additional support:
-Pal Care via LTC+
and other means

You as
expert

Ontario
Palliative Care
Network

Needs of People in LTC with serious Illness

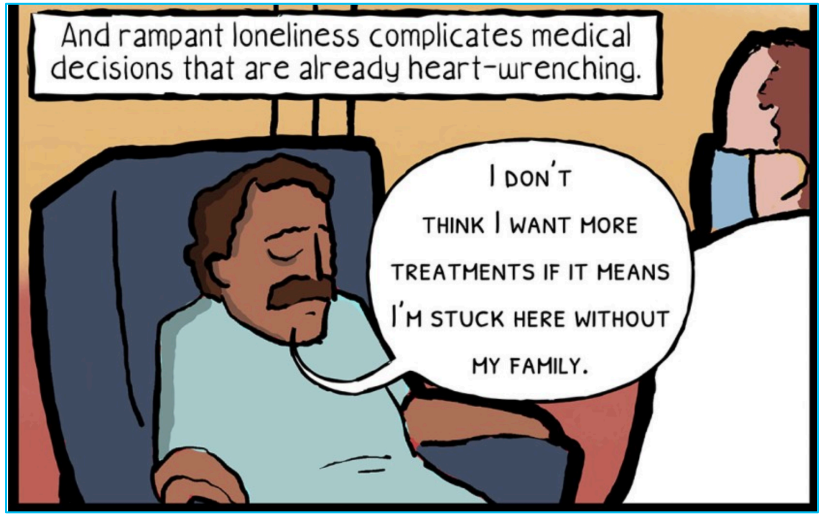
- Population:
  - Serious illness (LTC residents 65+, cognitively intact)
  - Toronto, ON

- Avoiding inappropriate prolongation of dying (#1)
- Strengthening relationships with loved ones
- Achieving a sense of control (e.g., GOC)
- Relief from pain and other symptoms
- Relief of burden onto family

Singer. JAMA 1999. 281(2): 163-168

Some Clinicians Have Referred For….

1. Complex symptom management
    - Refractory and Terminal Delirium
    - Refractory Dyspnea
2. Approach to discordant GOC between patient/family and clinical team



Cartoon credit: Nathan Gray, MD

Res

Ontario Palliative Care Network

Providing Palliative and End-of-Life Care for Residents in Long-Term Care During the COVID-19 Pandemic

RESOURCE TOOLKIT

Ontario Health

Providing Palliative and End-of-Life Care for Residents in Long-Term Care

Long-term Care (LTC) homes typically provide palliative and end of life care for residents, unless a resident has complex needs that require intensive or complicated medical assistance. This toolkit was developed to complement existing processes and procedures, and provide additional support to LTC leaders and providers providing palliative and end-of-life care in the context of COVID-19. The included resources provide practical information to help with communication and care planning, symptom management and pre- and post-death support for families as well as health care professionals during the pandemic.

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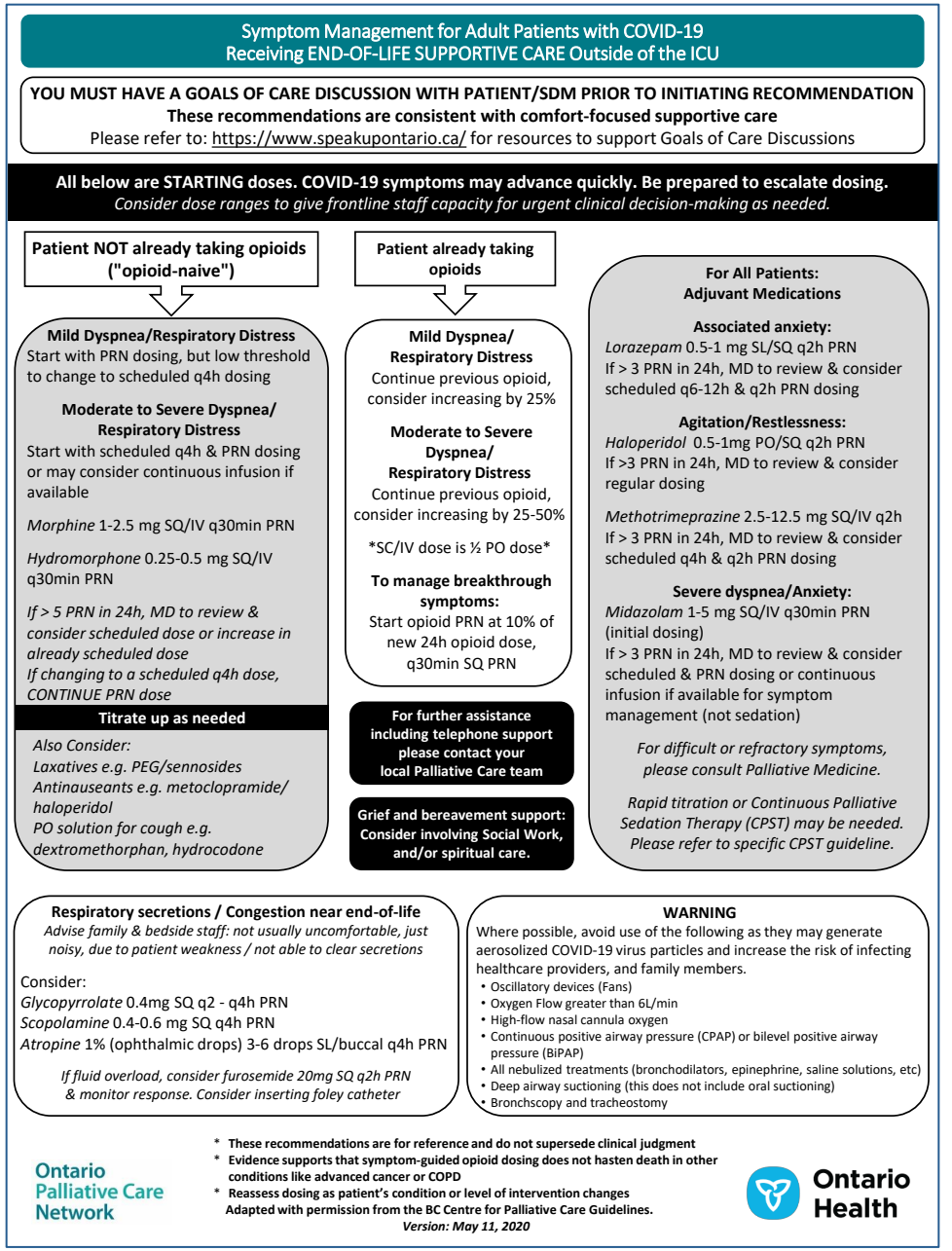
Symptom Management at EOL



Symptom Management for Adult Patients with COVID-19 Receiving END-OF-LIFE SUPPORTIVE CARE Outside of the ICU

YOU MUST HAVE A GOALS OF CARE DISCUSSION WITH PATIENT/SDM PRIOR TO INITIATING RECOMMENDATION
These recommendations are consistent with comfort-focused supportive care
Please refer to: https://www.speakupontario.ca/ for resources to support Goals of Care Discussions

All below are STARTING doses. COVID-19 symptoms may advance quickly. Be prepared to escalate dosing.
Consider dose ranges to give frontline staff capacity for urgent clinical decision-making as needed.

Patient NOT already taking opioids ("opioid-naive")

Mild Dyspnea/Respiratory Distress
Start with PRN dosing, but low threshold to change to scheduled q4h dosing

Moderate to Severe Dyspnea/ Respiratory Distress
Start with scheduled q4h & PRN dosing or may consider continuous infusion if available

Morphine 1-2.5 mg SQ/IV q30min PRN

Hydromorphone 0.25-0.5 mg SQ/IV q30min PRN

If > 5 PRN in 24h, MD to review & consider scheduled dose or increase in already scheduled dose
If changing to a scheduled q4h dose, CONTINUE PRN dose

Titrate up as needed

Also Consider:
Laxatives e.g. PEG/sennosides
Antinauseants e.g. metoclopramide/ haloperidol
PO solution for cough e.g. dextromethorphan, hydrocodone

Patient already taking opioids

Mild Dyspnea/ Respiratory Distress
Continue previous opioid, consider increasing by 25%

Moderate to Severe Dyspnea/ Respiratory Distress
Continue previous opioid, consider increasing by 25-50%

SC/IV dose is ½ PO dose

To manage breakthrough symptoms:
Start opioid PRN at 10% of new 24h opioid dose, q30min SQ PRN

For further assistance including telephone support please contact your local Palliative Care team

Grief and bereavement support: Consider involving Social Work, and/or spiritual care.

For All Patients: Adjuvant Medications

Associated anxiety:
Lorazepam 0.5-1 mg SL/SQ q2h PRN
If > 3 PRN in 24h, MD to review & consider scheduled q6-12h & q2h PRN dosing

Agitation/Restlessness:
Haloperidol 0.5-1mg PO/SQ q2h PRN
If >3 PRN in 24h, MD to review & consider regular dosing

Methotrimeprazine 2.5-12.5 mg SQ/IV q2h
If > 3 PRN in 24h, MD to review & consider scheduled q4h & q2h PRN dosing

Severe dyspnea/Anxiety:
Midazolam 1-5 mg SQ/IV q30min PRN (initial dosing)
If > 3 PRN in 24h, MD to review & consider scheduled & PRN dosing or continuous infusion if available for symptom management (not sedation)

For difficult or refractory symptoms, please consult Palliative Medicine.

Rapid titration or Continuous Palliative Sedation Therapy (CPST) may be needed. Please refer to specific CPST guideline.

Respiratory secretions / Congestion near end-of-life

Advise family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness / not able to clear secretions

Consider:
Glycopyrrolate 0.4mg SQ q2 - q4h PRN
Scopolamine 0.4-0.6 mg SQ q4h PRN
Atropine 1% (ophthalmic drops) 3-6 drops SL/buccal q4h PRN

If fluid overload, consider furosemide 20mg SQ q2h PRN & monitor response. Consider inserting foley catheter

WARNING

Where possible, avoid use of the following as they may generate aerosolized COVID-19 virus particles and increase the risk of infecting healthcare providers, and family members.

- Oscillatory devices (Fans)
- Oxygen Flow greater than 6L/min
- High-flow nasal cannula oxygen
- Continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP)
- All nebulized treatments (bronchodilators, epinephrine, saline solutions, etc)
- Deep airway suctioning (this does not include oral suctioning)
- Bronchscopy and tracheostomy

* **These recommendations are for reference and do not supersede clinical judgment**
* **Evidence supports that symptom-guided opioid dosing does not hasten death in other conditions like advanced cancer or COPD**
* **Reassess dosing as patient's condition or level of intervention changes**

Adapted with permission from the BC Centre for Palliative Care Guidelines.
Version: May 11, 2020

Ontario Palliative Care Network

Ontario Health

https://www.ontariopalliativecarenetwork.ca (Click on 'Resources')

Anticipatory Prescribing in LTC

- DNR/I
- No transfer to hospital
- GOC comfort-focused (symptom management)

- Common end-of-life symptoms
  - Dyspnea
  - Delirium/agitation
  - Secretions
  - Pain

Recommend having 1st and 2nd line agents prescribed (SC route)

-Consider Midaz 2mg SC q1h PRN

Delirium

- Education for bedside nurses
  - r/o reversible cause (constipation, urinary retention, etc.)
  - Analgesic – always assume pain 1st
  - Refractory symptoms:
    - Antipsychotic – 1st line
    - Benzodiazepine – 2nd line

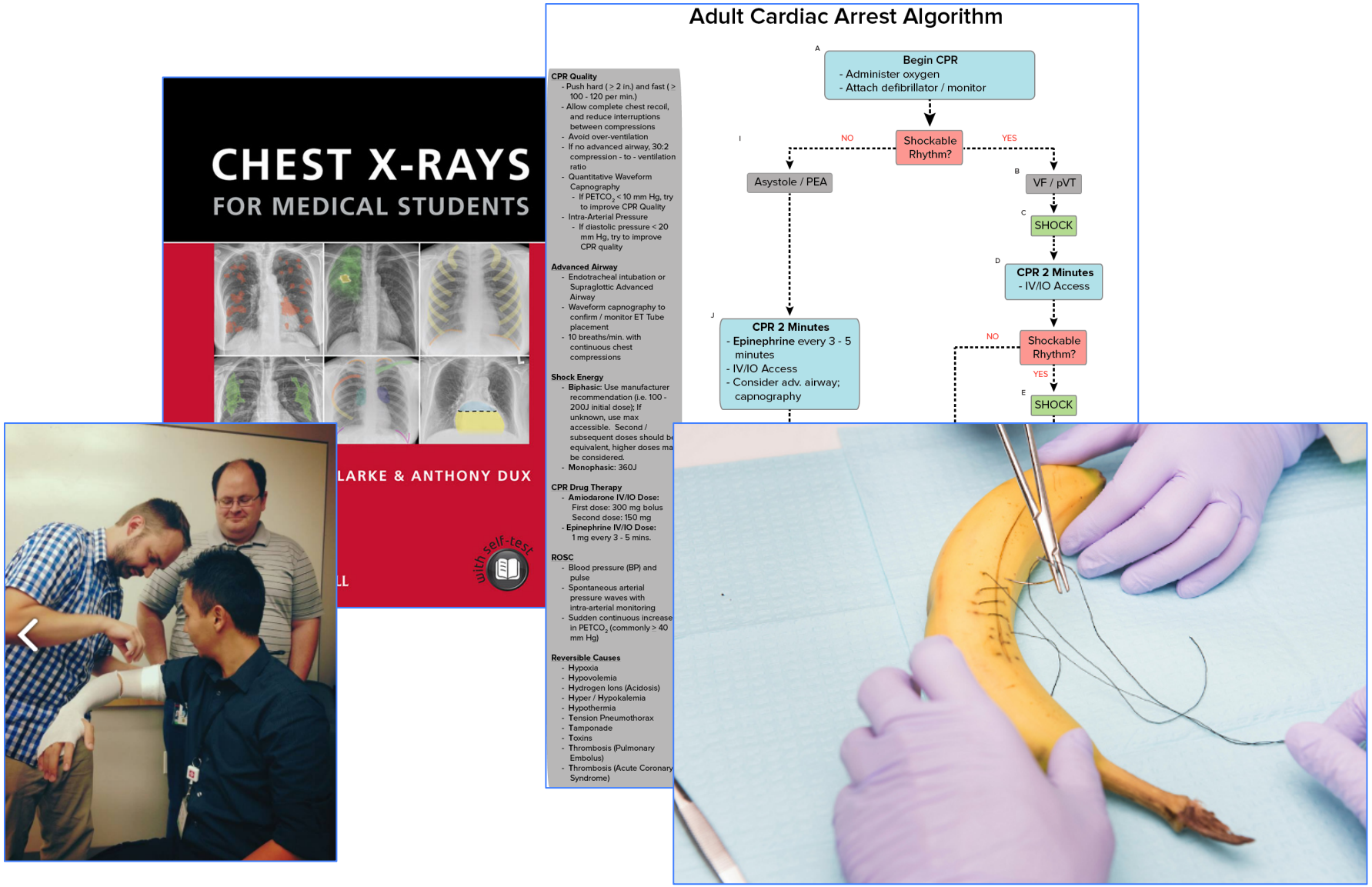
ACP / GOC


80%
of Canadians say they are
comfortable talking about their
end of life care and related issues

Addressing Barriers to ACP/GOC

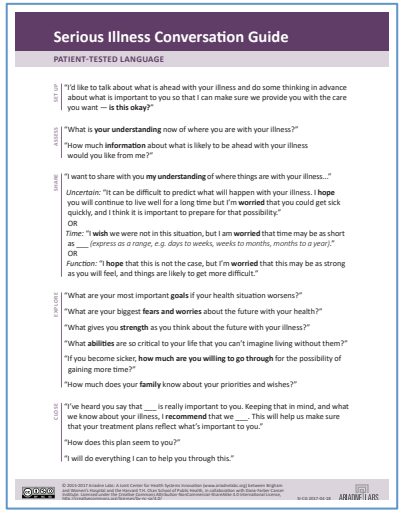
You're already doing a great job!

GOC Conversations as Procedures



GOC Conversations as Procedures

- Communication **Guides**
  - Improves patient outcomes[1]
  - “More, earlier, better quality” documented conversations[2]
  - Acceptable to patients and clinicians


Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

START

“I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**”

ASSESS

“What is **your understanding** now of where you are with your illness?”

“How much **information** about what is likely to be ahead with your illness would you like from me?”

ALIGN

“I want to share with you **my understanding** of where things are with your illness…”

Uncertain: “It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I’m **worried** that you could get sick quickly, and I think it is important to prepare for that possibility.”
OR
Time: “I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*.”
OR
Function: “I **hope** that this is not the case, but I’m **worried** that this may be as strong as you will feel, and things are likely to get more difficult.”

EXPLORE

“What are your most important **goals** if your health situation worsens?”

“What are your biggest **fears and worries** about the future with your health?”

“What gives you **strength** as you think about the future with your illness?”

“What **abilities** are so critical to your life that you can’t imagine living without them?”

“If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?”

“How much does your **family** know about your priorities and wishes?”

PLAN

“I’ve heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what’s important to you.”

“How does this plan seem to you?”

“I will do everything I can to help you through this.”

- Communication **Skills**
  - Increased clinician empathy [3]
  - Increased patient trust in provider[4]
  - Decreased patient anxiety[4]

VITAL talk

1. Bernacki et al, JAMA Int Med, 2019
2. Paladino et al, JAMA Onc, 2019
3. Tulsky 2011
4. Zwingmann et al. Cancer 2017

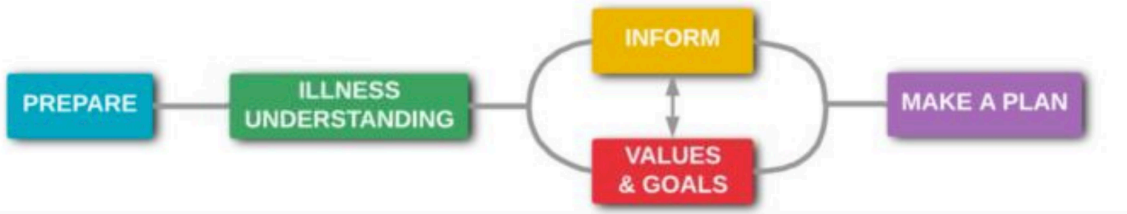
Conversation Guides

HPCO Hospice Palliative Care Ontario

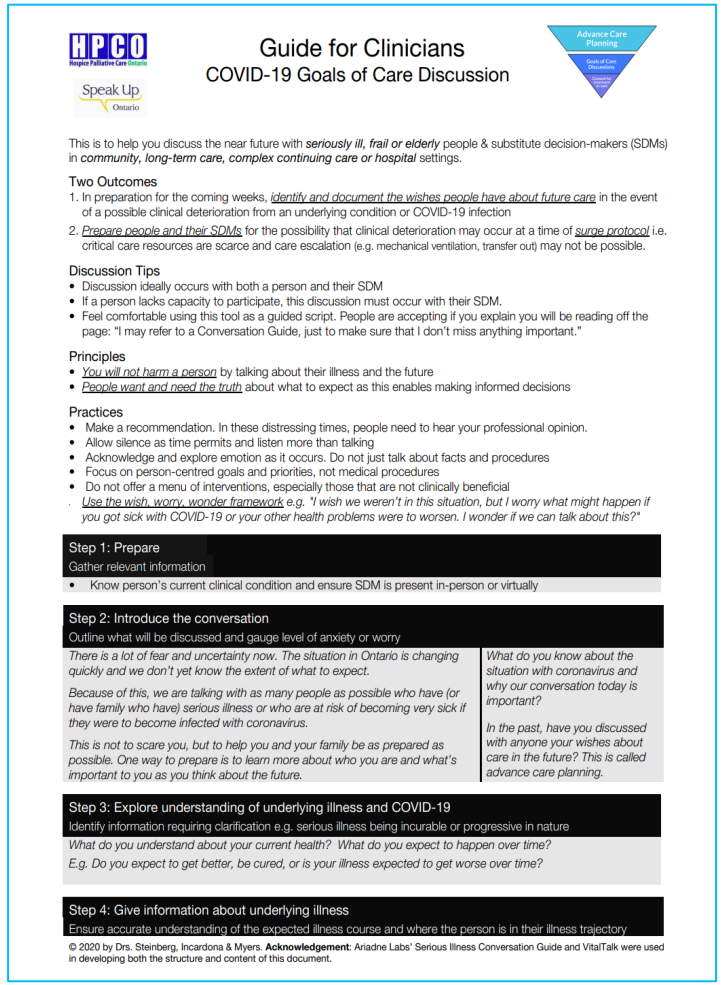
Speak Up Ontario

Guide for Clinicians
COVID-19 Goals of Care Discussion

Target Population:
1. Frail/Elderly or Serious underlying comorbidities
2. Long Term Care or other institution or home (adapt to location)
3. Severe COVID-19 Illness



Goal: To have an initial goals of care conversion, identify a substitute decision maker, and explore values and wishes in the case the patient's condition deteriorates



HPCO Hospice Palliative Care Ontario

Speak Up Ontario

Guide for Clinicians
COVID-19 Goals of Care Discussion

Advance Care Planning
Goals of Care Discussions
Consent for treatment or care

This is to help you discuss the near future with ***seriously ill, frail or elderly*** people & substitute decision-makers (SDMs) in ***community, long-term care, complex continuing care or hospital*** settings.

Two Outcomes
1. In preparation for the coming weeks, *identify and document the wishes people have about future care* in the event of a possible clinical deterioration from an underlying condition or COVID-19 infection
2. *Prepare people and their SDMs* for the possibility that clinical deterioration may occur at a time of *surge protocol* i.e. critical care resources are scarce and care escalation (e.g. mechanical ventilation, transfer out) may not be possible.

Discussion Tips
- Discussion ideally occurs with both a person and their SDM
- If a person lacks capacity to participate, this discussion must occur with their SDM.
- Feel comfortable using this tool as a guided script. People are accepting if you explain you will be reading off the page: "I may refer to a Conversation Guide, just to make sure that I don't miss anything important."

Principles
- *You will not harm a person* by talking about their illness and the future
- *People want and need the truth* about what to expect as this enables making informed decisions

Practices
- Make a recommendation. In these distressing times, people need to hear your professional opinion.
- Allow silence as time permits and listen more than talking
- Acknowledge and explore emotion as it occurs. Do not just talk about facts and procedures
- Focus on person-centred goals and priorities, not medical procedures
- Do not offer a menu of interventions, especially those that are not clinically beneficial
- *Use the wish, worry, wonder framework e.g. "I wish we weren't in this situation, but I worry what might happen if you got sick with COVID-19 or your other health problems were to worsen. I wonder if we can talk about this?"*

Step 1: Prepare
Gather relevant information
- Know person's current clinical condition and ensure SDM is present in-person or virtually

Step 2: Introduce the conversation
Outline what will be discussed and gauge level of anxiety or worry

There is a lot of fear and uncertainty now. The situation in Ontario is changing quickly and we don't yet know the extent of what to expect.

Because of this, we are talking with as many people as possible who have (or have family who have) serious illness or who are at risk of becoming very sick if they were to become infected with coronavirus.

This is not to scare you, but to help you and your family be as prepared as possible. One way to prepare is to learn more about who you are and what's important to you as you think about the future.

What do you know about the situation with coronavirus and why our conversation today is important?

In the past, have you discussed with anyone your wishes about care in the future? This is called advance care planning.

Step 3: Explore understanding of underlying illness and COVID-19
Identify information requiring clarification e.g. serious illness being incurable or progressive in nature

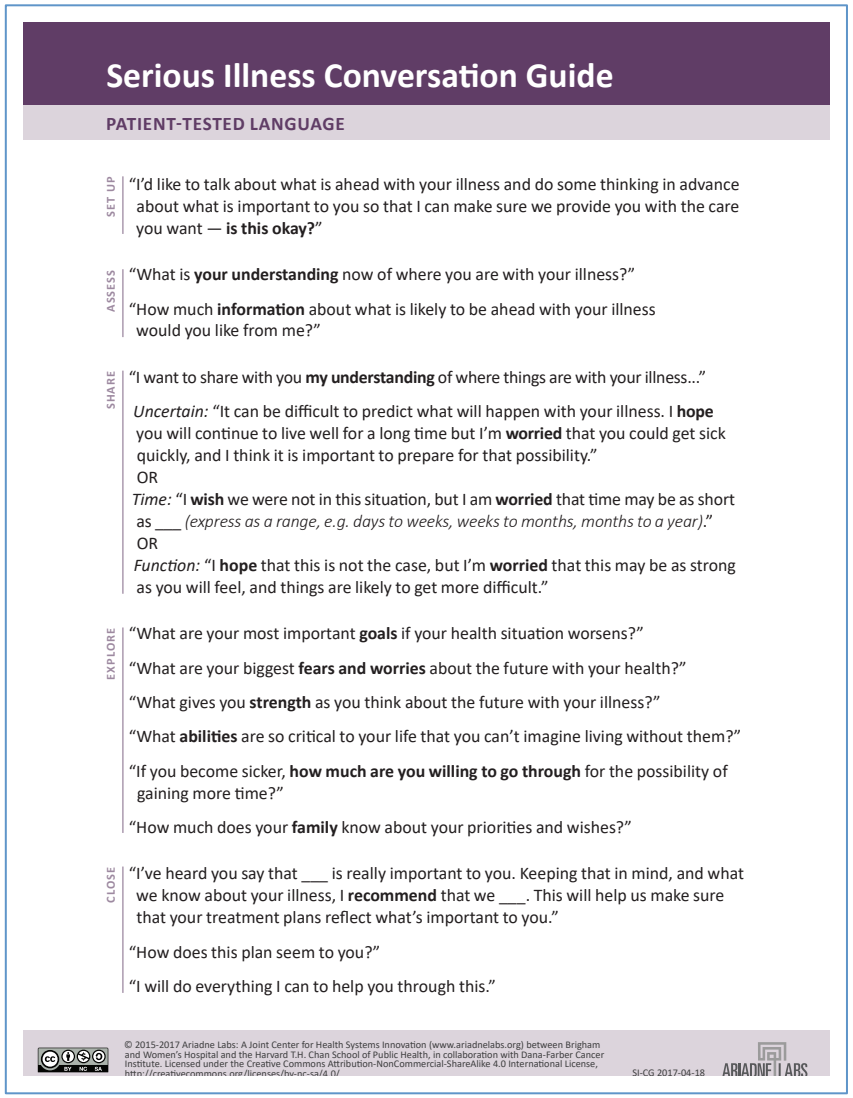
What do you understand about your current health? What do you expect to happen over time?

E.g. Do you expect to get better, be cured, or is your illness expected to get worse over time?

Step 4: Give information about underlying illness
Ensure accurate understanding of the expected illness course and where the person is in their illness trajectory

Speakupontario.ca

Conversation Guides



Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

ASSESS

"What is **your understanding** now of where you are with your illness?"

"How much **information** about what is likely to be ahead with your illness would you like from me?"

SHARE

"I want to share with you **my understanding** of where things are with your illness..."

Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."
OR
Time: "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*."
OR
Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

EXPLORE

"What are your most important **goals** if your health situation worsens?"

"What are your biggest **fears and worries** about the future with your health?"

"What gives you **strength** as you think about the future with your illness?"

"What **abilities** are so critical to your life that you can't imagine living without them?"

"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

"How much does your **family** know about your priorities and wishes?"

CLOSE

"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

"I will do everything I can to help you through this."

SI-CG 2017-04-18

ARIADNE LABS

1. Evidence & Feasible
2. Adaptable
3. Top → Bottom
4. Build towards making a **recommendation** based on values
5. COVID-specific

Ariadnelabs.org (serious illness care)

Video Demo

https://youtu.be/FMPjx9-bpBo

Simulated Phone Call with a Family Member using the COVID-19 Conversation Guide for Long-Term Care

To support clinicians in having difficult conversations with family members of patients in long-term care facilities and may be high risk for serious complic...

youtu.be

Making a Recommendation

After a values-based conversation you may **recommend** shifting the focus of care to prioritize comfort in LTC

1. Ask for permission: *"Would it be okay if I make a recommendation?"**

2. Put into context of stated values: *"Based on what you've shared with me today I would recommend the following….."*

3. First say what you **will** do: *"We will focus on prioritizing their comfort in the following ways……."*

4. Second say what you **will not** do: *"We won't send her to the hospital or include CPR, breathing tubes as part of her care plan because that will not help her to feel comfortable and will not help her to achieve her goals of [x,y,z]."*

5. Ask for their thoughts: *"I imagine this is difficult to discuss. How does this plan sound to you?"*

* Schedule follow-up or set up a 'what if'/future scenario

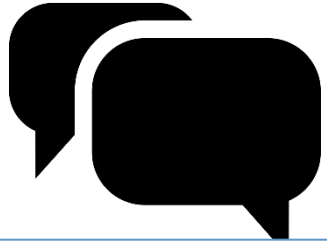
I. NURSE Statements

- Phrases that articulate empathy in response to emotion
- Builds rapport by aligning you and your patient/family and allows them to feel heard
- Helpful because emotions are processed faster than cognitive information

Skill		Examples
N	**N**ame	It sounds like you are upset* to hear this news. (*worried, angry, surprised, relieved)
U	**U**nderstand	This helps me understand why this news is so unsettling. I can't imagine how difficult it must be to hear this information.
R	**R**espect	I admire your strength and courage during these uncertain times.
S	**S**upport	Our team will do everything that is in our power to support and care for you.
E	**E**xplore	What could I do to help support you today?

Back, Arnold, and Tulsky. Mastering Communication with Seriously Ill Patients. Cambridge Univ. Press.

NURSE Statements in COVID



What they say	What you say	Type of NURSE Statement
Is my grandfather going to make it?	**I imagine you are scared.** Here's what I can say:	NAME
Are you saying that no one can visit me?	**I imagine it is hard to not have visitors.** The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. They will be in more danger if they come into the hospital. I wish things were different.	UNDERSTAND
How can you not let me in for a visit?	**I can see you love your [x] so much.**	RESPECT
How bad is this?	From the information I have now and from my exam, your situation is serious enough that you should be in the hospital. We will know more in the next day, and we will update you then. **Your team is here 24/7 for you.**	SUPPORT
Does this mean I have COVID19?	We will need to test you with a nasal swab, and we will know the result by tomorrow. It is normal to feel stressed when you are waiting for results. **Tell me more about what concerns you most?**	EXPLORE

Deciding

When things aren't going well, goals of care, code status

What they say	What you say
I want everything possible. I want to live.	We are doing everything we can. This is a tough situation. Could we step back for a moment so I can learn more about you? **What do I need to know about you to do a better job taking care of you?**
I don't think my spouse would have wanted this.	Well, let's pause and talk about what they would have wanted. Can you tell me what they considered most important in their life? **What meant the most to them, gave their life meaning?**
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. **Can you say more about what you mean?**
I am not sure what my spouse wanted—we never spoke about it.	You know, many people find themselves in the same boat. This is a hard situation. To be honest, given their overall condition now, if we need to put them on a breathing machine or do CPR, they will not make it. The odds are just against us. **My recommendation is that we accept that he will not live much longer and allow him to pass on peacefully**. I suspect that may be hard to hear. What do you think?

https://www.vitaltalk.org/guides/covid-19-communication-skills/

II. “Wish/Worry” statements

- **When patient or family has an <u>unrealistic treatment goal/hope</u>**

- **“Wish/Worry”** statements:
  - “I wish the hospital had treatments that could make your dad stronger.”
  - “Unfortunately, I worry the hospital treatments may harm your dad without giving him a chance to be saved in the way you are hoping.”

- **Aligning yourself with patient/family goals:**
  - “I wish we could allow visitors. I’m worried if they were here they could get sick or make you sicker.”

- **Can be helpful if people are uncomfortable having a GOC discussion**
  - “I wish we didn’t have to have this conversation. I’m worried if we don’t, we won’t know how to provide your mom with the care that she’d want.”

Referring to Palliative Care

Language that patients/families prefer to hear:

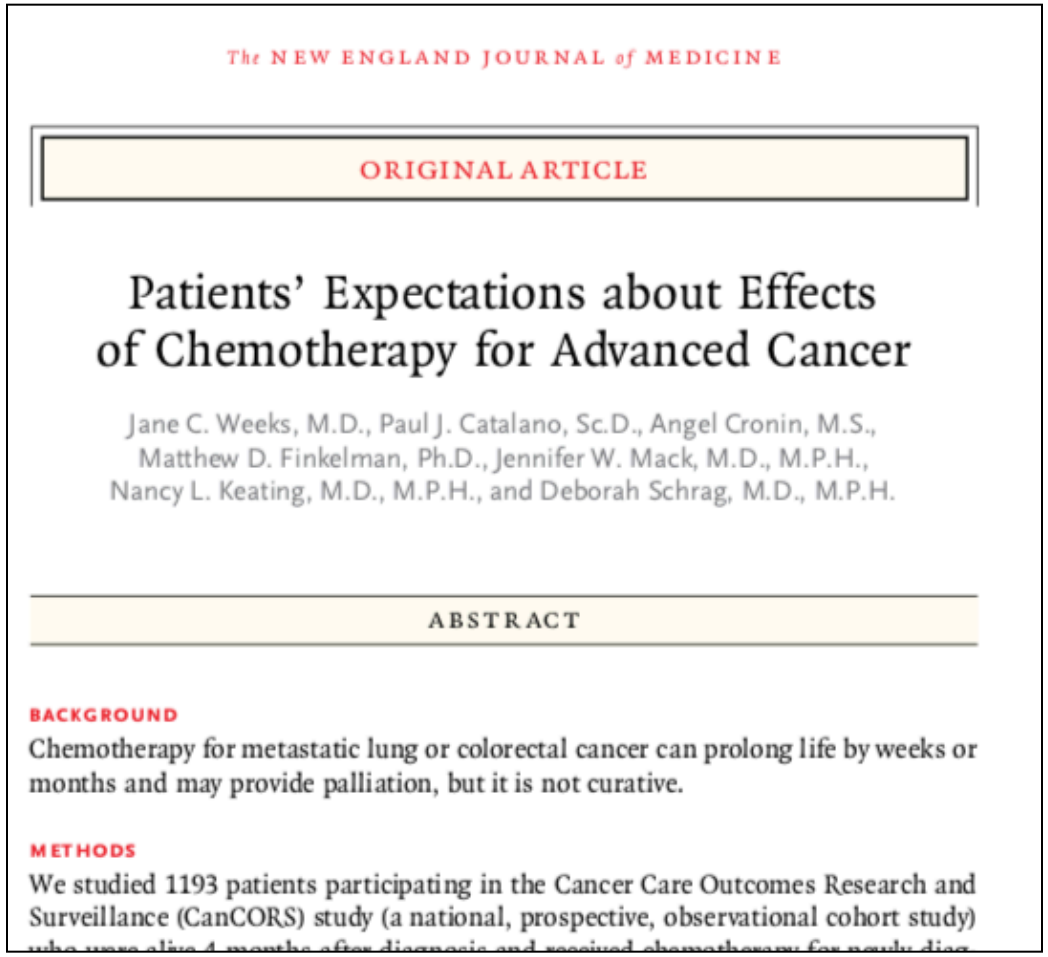
- *"I'd like to refer you to a team that can help us better manage the stress and symptoms associated with your illness. At our LTC home we can call a palliative care specialist that is expert in this area. I'm going to ask for them to help us ensure we've got everything you/your loved one needs to be comfortable."*

Calling Palliative Care through LTC+:

- Recommendation for refractory symptoms
- Advice for challenging GOC discussions
- Recommendation for helpful online or print resources

THANK YOU.

Current State



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Patients' Expectations about Effects of Chemotherapy for Advanced Cancer

Jane C. Weeks, M.D., Paul J. Catalano, Sc.D., Angel Cronin, M.S., Matthew D. Finkelman, Ph.D., Jennifer W. Mack, M.D., M.P.H., Nancy L. Keating, M.D., M.P.H., and Deborah Schrag, M.D., M.P.H.

ABSTRACT

BACKGROUND

Chemotherapy for metastatic lung or colorectal cancer can prolong life by weeks or months and may provide palliation, but it is not curative.

METHODS

We studied 1193 patients participating in the Cancer Care Outcomes Research and Surveillance (CanCORS) study (a national, prospective, observational cohort study)

- 69% of patients with incurable lung cancer and 81% of patients with incurable colorectal cancer did not report understanding that their chemotherapy was not for cure

Weeks et al., 2012 NEJM

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