

Palliative Care Journal Watch

A partnership between Pallium Canada and the Divisions of Palliative Care at Queen's University in Kingston, Canada, and McMaster University in Hamilton, Canada



Queen's University
SCHOOL OF MEDICINE | DEPARTMENT OF
Medicine



Family Medicine

Hosts: Dr. José Pereira & Dr. Leonie Herx

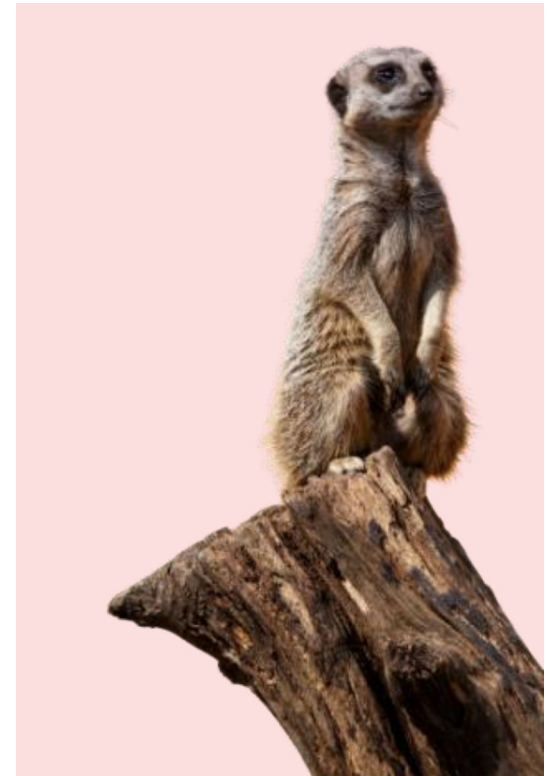
Guest Panelists:

Dr. Aynharan Sinnarajah &
Dr. Jesse Solomon

Date: September 18th, 2023

Welcome to the Palliative Care Journal Watch!

- Keeps you up to date on the latest peer-reviewed palliative care literature.
- Led by palliative care experts from the divisions of palliative care at some Canadian Universities:
 - McMaster University, Queen's University, University of Manitoba, University of Alberta, University of Toronto, and Hadassah-Hebrew University Medical Center in Israel.
- We regularly monitor over 20 journals and highlight papers that challenge us to think differently about a topic or confirm our current practices.
- This is a journal watch, and not a journal club
 - Not in-depth analyses of each manuscript selected.



The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



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What to Expect from Today's Session

- We will present and discuss, as a panel, the top 4 to 5 articles selected for this episode
- Provide a list of honourable mentions.
- Please submit questions through the Q&A function.
- Session is being recorded and will be shared with registrants within the next week.
- Recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.
- Check out the Palliative Care Journal Watch Podcast.
- This 1 credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **8 Mainpro+ credits** (each 1-hour session is worth 1 Mainpro+ credit).

Introductions

Hosts

Dr. José Pereira, MBChB, CCFP(PC), MSc, FCFP, PhD

Professor, Division of Palliative Care, Department of Family Medicine, McMaster University, Hamilton, ON, Canada

Scientific Advisor and Co-Founder, Pallium Canada
Professor, Faculty of Medicine, University of Navarra, Spain

Dr. Leonie Herx, MD, PhD, CCFP(PC), FCFP
Palliative Care Consultant

Guest Panelists

Dr. Aynharan Sinnarajah, MD CCFP(PC) MPH

Chair, Dr. Gillian Gilchrist Palliative Care Research, Division of Palliative Care, Queen's University / Lakeridge Health, ON, Canada

Dr. Jesse Solomon, MD, FRCPC

Palliative Care and General Internal Medicine
Assistant Clinical Professor
Division of Palliative Care | Department of Medicine
McMaster University
St. Peter's Hospital, Hamilton Health Sciences

Disclosures

Pallium Canada

- Not-for-profit.
- Funded mainly by:
 - Health Canada (through contribution agreements 2001-2007, 2013-2018, 2021-2025 for ECHO).
 - Partnerships (e.g. provincial ministries and organizations, service providers).
 - Revenues from LEAP course registration fees and licenses, and sales of Pallium Palliative Pocketbook.

Disclosures of Host/Guest Panelists:

- Dr. José Pereira: Scientific Advisor, Pallium Canada.
- Dr. Leonie Herx: No conflicts of interest to declare.
- Dr. Jesse Solomon: No conflicts of interest to declare.
- Dr. Aynharan Sinnarajah: No conflicts of interest to declare.

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content.

Featured articles

1. Dzung E, Batten JN, Dohan D, Blythe J, Ritchie CS, Curtis JR. **Hospital Culture and Intensity of End-of-Life Care at 3 Academic Medical Centers.** JAMA Intern Med. 2023 Aug 1;183(8):839-848. doi: 10.1001/jamainternmed.2023.2450. PMID: 37399038; PMCID: PMC10318547.
2. Chan LML, Yan OY, Lee JJJ, Lam WWT, Lin CC, Auyeung M, Bloem BR, Kwok JYY. **Effects of Palliative Care for Progressive Neurologic Diseases: A Systematic Review and Meta-Analysis.** J Am Med Dir Assoc. 2023 Feb;24(2):171-184. doi: 10.1016/j.jamda.2022.11.001. Epub 2022 Dec 5. PMID: 36481217.
3. Curtis JR, Lee RY, Brumback LC, Kross EK, Downey L, Torrence J, LeDuc N, Mallon Andrews K, Im J, Heywood J, Brown CE, Sibley J, Lober WB, Cohen T, Weiner BJ, Khandelwal N, Abedini NC, Engelberg RA. **Intervention to Promote Communication About Goals of Care for Hospitalized Patients With Serious Illness: A Randomized Clinical Trial.** JAMA. 2023 Jun 20;329(23):2028-2037. doi: 10.1001/jama.2023.8812. PMID: 37210665; PMCID: PMC10201405.
4. Koh SJQ, Sim DKL, Neo SH. **Letter to the Editor: Educating Patients With Advanced Heart Failure Through Chat Generative Pretrained Transformer and Natural-Language Artificial Intelligence: Is Now the Time for It?** J Palliat Med. 2023 Jul;26(7):893-895. doi: 10.1089/jpm.2023.0199. PMID: 37428968
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Hospital Culture and Intensity of End-of-Life Care at 3 Academic Medical Centers

Article Reference:

Dzeng E, Batten JN, Dohan D, Blythe J, Ritchie CS, Curtis JR. JAMA Intern Med. 2023 Aug 1;183(8):839-848. doi: 10.1001/jamainternmed.2023.2450. PMID: 37399038; PMCID: PMC10318547.

Selected by:

José Pereira

Presented by:

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Background

There is substantial institutional variability in the intensity of end-of-life care that is not explained by patient preferences.

Hospital culture and institutional structures (eg, policies, practices, protocols, resources) might contribute to potentially nonbeneficial high-intensity life-sustaining treatments near the end of life.

Goal

- To understand the role of hospital culture in the everyday dynamics of high-intensity end-of-life care.
- **Research question:** What is the role of hospital culture and institutional structures in the provision of potentially nonbeneficial, high-intensity life-sustaining treatments near the end of life?

Methods

- Qualitative study: comparative ethnographic study
- Conducted at 3 academic hospitals in California and Washington that differed in end-of-life care intensity based on measures in the Dartmouth Atlas
- Semi-structured, in-depth interviews conducted by 2 researchers
- Participants included hospital-based clinicians, administrators, and leaders.
- Purposive sampling (interviews Dec 2018 to June 2022)
- Data were deductively and inductively analyzed using thematic analysis through an iterative coding process. Coding and themes done through consensus by 5 researchers.

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Main Results

- 113 participants
- Similarities noted between experiences at low-intensity and medium-intensity hospitals as distinct from the high-intensity hospital.
- Potentially nonbeneficial, high-intensity life-sustaining treatments occurred at all hospitals, as well as defaults toward high-intensity care (respondents felt this reflected cultural norms in the US).
- However, respondents at each of the 3 sites also described distinct hospital cultures around the intensity of end-of-life care that differed between sites
 - High-intensity care was particularly notable at the high-intensity hospital
 - Receptiveness toward palliative care and a mindset toward deescalation at the lower-intensity hospitals
- Proactive, concerted efforts among multiple care teams were required to deescalate high-intensity treatments.
- Efforts to deescalate were vulnerable to being undermined at multiple points during a patient's care trajectory by any individual or entity.
- Respondents at different hospitals reported different policies, protocols, resources and practices that encouraged or discouraged de-escalation of nonbeneficial life-sustaining treatments.

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Strengths and Limitations

- Strength: Large and robust qualitative study, providing in-depth understanding
- Limitation: Some differences between hospitals may affect intensity of care (e.g., uptake of palliative care, economic incentives, patient population demographics).
- 3 US urban academic medical centers (may not generalize to smaller community hospitals or hospitals in other countries)

Summary of Key Points

- Study describes the significance of hospital culture and institutional structures in resisting the default toward high-intensity life-sustaining treatments.

Importance Of Article

- Institutional structures and hospital cultures shape the everyday dynamics by which clinicians may deescalate end-of-life patients from this trajectory.
- Individual behaviors or interactions may fail to mitigate potentially nonbeneficial high-intensity life-sustaining treatments if the hospital culture or a lack of supportive policies and practices undermine individual efforts.
- Hospital cultures need to be considered when developing policies and interventions to decrease potentially nonbeneficial, high-intensity life-sustaining treatments.

Discussion

Effects of Palliative Care for Progressive Neurologic Diseases: A Systematic Review and Meta-Analysis

Article Reference:

Chan LML, Yan OY, Lee JJJ, Lam WWT, Lin CC, Auyeung M, Bloem BR, Kwok JYY. J Am Med Dir Assoc. 2023 Feb;24(2):171-184. doi: 10.1016/j.jamda.2022.11.001. Epub 2022 Dec 5. PMID: 36481217.

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Background

- Progressive neurologic diseases (e.g. Alzheimer's disease, Parkinson disease, multiple sclerosis, and motor neuron disease) affect millions of people worldwide.
- Characterized by mobility dysfunctions and nonmotor symptoms.
- Patients and caregivers experience substantial distress and burden.
- There are calls for the integration of palliative care in the care of these patients
- 3 previous studies highlighted (Oliver et al 2016; Latorraca et al 2019 ; Walsh et al): Limited evidence of impact found

Goals

- To determine the association of palliative care for progressive neurologic diseases with patient- and caregiver-centered outcomes.

Methods

- Systematic review and meta-analysis of randomized controlled trials and quasi-experimental studies, including pilot studies.
- Adults with progressive neurologic diseases (dementia, multiple sclerosis, Parkinson's disease, motor neuron disease, multiple system atrophy, and progressive supranuclear palsy) and their caregivers.
- 5 databases searched, independent screening by 2 reviewers,. A narrative synthesis was conducted. Pt QOL, symptom burden, caregiver burden, and satisfaction with care were meta-analyzed using a random-effects model.

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Main Results

- 27 articles included:
 - 15 were trials with over 3431 pts and patients and over 1776 caregivers
 - Multiple sclerosis, Parkinson disease, mixed neurodegenerative diseases, nursing home residents with dementia.
- Different palliative care interventions
 - interdisciplinary teams, home visits, palliative care clinician, and spiritual care.
 - multipronged strategies and addressed different domains.
 - 9 studies evaluated caregiver outcomes
- Quality of the studies
 - Different levels of risk across RCT studies
- **Quantitative Synthesis**

Domain	Studies	Meta-analysis
QOL (7 trials)	3 reported statistically significant improvements in the pall care groups compared to usual care.	6 studies, found palliative care was not significantly associated with better QoL
Symptom burden (11 trials)	4 reported significant improvements in the palliative care groups	Pall Care was significantly associated with lower symptom burden
Caregiver burden (9 trials)	4 reported significant reductions in caregiver burden in patients who received Pall Care compared to ...	No significant difference found
Satisfaction with care (4 studies)	All 4 reported higher patient satisfaction in pall care groups	Statistically significant difference confirmed in meta-analysis.

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Main Results Continued

• Qualitative Synthesis

Domain	Studies
Patient outcomes	1 of 5 trials on psychological wellbeing reported significant impact. None of 2 trials on spiritual wellbeing found impact
Caregiver outcomes	1 of 3 trials on caregiver QOL found significant impact. 1 of 2 trials on caregiver psychological wellbeing, found significant anxiety reduction. No impact on depression.
Quality of care outcomes	2 of 3 trials reported improved quality of care in pall care groups. 1 of 3 on ACP showed significant increases in ACP in pall care groups 2 of 3 studies found more preference and GoC documentation in pall care groups
Pall care in nursing homes	Multifaceted interventions (including staff training, etc) 4 trials, of which 2 reported significant improvement in quality of care (reported by family, and quality of dying)

When the high-risk studies were removed from the analyses, palliative care was not found to be associated with improved QOL, symptom burden, caregiver burden, patient satisfaction and caregiver satisfaction compared to usual care.

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Strengths and Limitations

- Strength: rigorous methods
- Limitation: Study heterogeneity, small number of trials

Summary of Key Points

- Palliative care is likely to improve symptom burden and satisfaction with care among patients with progressive neurologic diseases and their caregivers, while its effects on QoL and caregiver burden remains inconclusive.
- Specific intervention components including interdisciplinary team, palliative care physicians, home visits, and spiritual care appeared to be associated with increased effects on improving palliative outcomes. More rigorous designed studies are warranted to examine the effects of neuropalliative care, effective intervention components, optimal timing, and symptom triggers of palliative care referrals.

Importance of article

- Highlights need for, and role of, palliative care in patients with progressive neurological diseases.
- There are signals for positive impact and benefits of palliative care compared to “usual care”.
- Ongoing research needed to improve interventions.

Discussion

Intervention to Promote Communication About Goals of Care for Hospitalized Patients With Serious Illness: A Randomized Clinical Trial

Article Reference:

Curtis JR, Lee RY, Brumback LC, Kross EK, Downey L, Torrence J, LeDuc N, Mallon Andrews K, Im J, Heywood J, Brown CE, Sibley J, Lober WB, Cohen T, Weiner BJ, Khandelwal N, Abedini NC, Engelberg RA. JAMA. 2023 Jun 20;329(23):2028-2037. doi: 10.1001/jama.2023.8812. PMID: 37210665; PMCID: PMC10201405.

Selected by:

Aynharan Sinnarajah

Presented by:

Aynharan Sinnarajah

Summary of Key Points

- Goals-of-care discussions are important for seriously ill patients, but often not done or documented well in health systems.
- Intervention: A bidirectional intervention (**Jumpstart Guide**) that uses patient surveys and communication prompts to facilitate goals-of-care discussions between patients and clinicians.
- Previous RCTs showed that this intervention increased the incidence and quality of goals-of-care discussions for outpatients and hospitalized patients with serious illness.
 - Resource-intensive (surveying patients or family members before the discussion).
 - Time-intensive (manual review of GoC documentation of goals-of-care discussions).
- EHRs: Opportunity to screen for patients and measure documentation more efficiently and thus, scalable.
 - Also, examine differential effects by age, sex, dementia, minoritized race/ethnicity, study site.

Methods

- Pragmatic, parallel, 1:1 RCT of intervention (Jumpstart Guide) vs Usual care.
- 3 academic hospitals at Univ of Washington Medicine (2 teaching hospitals (incl trauma), 1 community hospital (serves geriatric, LTC home)).
- >80yo OR >55yo + Presence of 1 or more of 9 chronic conditions (dementia, cancer of poor prognosis, COPD, CAD, CHF, chronic liver disease, CKD, diabetes with end-organ damage, PVD).
- Exclusion: Comfort care goals, Palliative care consults already, Documented GoC.
- Automated EHR email with patient-specific info (from EHR) + example language for conducting discussion to MRP + resident physicians. Also 1 page sent re: email.
- Natural Language Processing (+human abstraction) to identify **Goals of care discussion** (Primary outcome) within 30d of randomization. NB: Code status order NOT considered GoC discussion.

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Key Results and Findings

- 2512 enrolled (1255 to intervention).
- White (70%), Black (13%), Hispanic (6%).
- Intervention group: 34.5% GoC discussion documentation vs Usual Care group of 30.4% (4.1% difference).
- Larger effect on patients with minoritized race / ethnicity (10.2% higher in intervention group vs 1.6% in non-Hispanic White).
- No differential effect on primary outcome by age, sex, dementia or study site.
- No impact on secondary outcomes (ICU, ED visit, hospital LOS, Discharge %).

Figure 2. Example of Intervention

Jumpstart Guide: a UW Medicine program

Your patient may benefit from a goals of care talk

We have chosen your patient based on a diagnosis of ≥ 1 chronic illnesses. Please treat the patient health information on this guide as confidential—okay to share with team.

Your patient: John Doe, MRN: H1234567

Code status	Full code	mm/dd/yyyy
Advance directive	Yes	mm/dd/yyyy
Durable power of attorney for health care	No	
Physician Orders for Life-Sustaining Treatment	No	

1. Give yourself 5-10 min. The conversation does not have to be long.
2. Introduce the talk as a routine part of care. Some patients are reluctant—do not start with death or CPR.

"I want to know what's important to you so that we provide the best care to fit your goals. Is that okay?"
3. Pick the best topics for your patient. You do not have to do them all.

Topics	Words to try
Understanding	"What have other doctors told you about how serious your illness is and what to expect?"
Acceptable status	"What abilities are so important to you that you can't imagine living without them?"
Values	"If you were to get sicker, what would be most important to you?"
4. Document a short note. A brief summary and a quote (a few of the patient's words) are enough. Your colleagues will appreciate it.

Optional feedback

Select an option below to send us feedback on this message.

☐ Will definitely do ☐ Will do if time allows ☐ Maybe, will consider

☐ Not appropriate ☐ Already done ☐ Other

Brought to you by UW Medicine and the (study name) Research Team. To reach us, call (telephone No.) or email (study staff contact) Date created: mm/dd/yy

The intervention was emailed to clinicians on the day of patient randomization and a message was sent to clinicians via their pagers to alert them to the presence of the intervention in their email box. CPR indicates cardiopulmonary resuscitation.

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Summary of Key Discussion Points

- Jumpstart Guide is helpful. Also found to increase GoC conversations in outpatients (also had patient-facing version).
- But magnitude of increase small, and unclear clinical significance.
- Perhaps part of multifaceted intervention and requires patient facing activation too
- Perhaps documentation is still poor quality, or difficult to find in EHR by other clinicians.
- Important racial / ethnic disparities in Palliative EOL care (less likely to receive hospice, more likely to receive higher intensity care near EOL, concerns re: quality of care and clinician communication). Perhaps GoC discussion interventions can help with equity in serious illness communication.

Additional thoughts

- Improved GoC discussions + documentation still doesn't lead to health resource outcomes, which is what most studies show.
- Pragmatic design leveraging EHR to make it easier to screen for appropriate patients, offer suggested language on having conversation and then measuring outcomes, makes it easier to spread and scale. Similar concept to HOMR projects in Ontario that a number of hospitals working on.

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Why is this article important and why does it have the potential to change practice?

- It's no longer enough to just add ACP policy, provide more education. Those don't usually work to change practice. QI/ Implementation projects that serve to screen appropriate patients, and offer specific actions seem to work better.
- It's still unclear whether all of this leads to better care, but most ACP experts agree that it does help. It's just that health resource measurement is probably not right metric to measure for these.

Strengths

- Leverage EHR tools to make it more efficient.
- Patient specific recommendations using patient record / clinical info.

Limitations

- 1 region only.
- Perhaps differential Natural Language processing performance by minoritized race /ethnicity or intervention vs usual care group (authors say unlikely).
- actual GoC quality hard to measure and what's important to add.
- multiple racial / ethnic groups combined into single category to analyse differential treatment effects.

Discussion

Letter to the Editor: Educating Patients With Advanced Heart Failure Through Chat Generative Pretrained Transformer and Natural-Language Artificial Intelligence: Is Now the Time for It?

Article Reference:

Koh SJQ, Sim DKL, Neo SH. J Palliat Med. 2023 Jul;26(7):893-895. doi: 10.1089/jpm.2023.0199. PMID: 37428968

Selected by:

Jesse Solomon

Presented by:

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Summary of Key Points

Natural language AI, such as Chat GPT, is a powerful tool given its accessibility reported proficiency in through passing the United States Medical Licensing Exam. The author asked Chat GPT questions about palliative care and advanced heart failure.

Summary of key position(s) taken by authors and why

Some answers given were appropriate, however there were notable inaccuracies and deficiencies. It is simply not ready for practice despite palliative care resources being stretched.

Additional comments/thoughts

I do believe Chat GPT is a tremendous program, however I also agree with the author. Perhaps in the future the model would be so sophisticated, beyond what I can even imagine, that its future may be imbedded in health care in several facets. Given its lack of reliability, I do worry that people in the community using this model could obtain incorrect information that affects their care. Given Chat GPT continues to learn and evolve, how sure are we that its evolution will always be towards truth and being correct?

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895. doi: 10.1089/jpm.2023.0199.
PMID: 37428968

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Why is this important?

It is topical since AI is making its way into discussions in all fields, including medicine.

Strengths

- Asked relevant questions to Chat GPT.
- Topical.
- Highlighted limitations to the model that limits its usefulness at this time.

Limitations

- Snapshot in time – chat gpt continues to evolve.

Discussion

Physiotherapy applied to palliative care patients: a descriptive practice-based study. BMC Palliat Care

Article Reference:

Navarro-Meléndez A, Gimenez MJ, Robledo-Donascimento Y, Río-González A, Lendínez-Mesa A. 2023 Jul 20;22(1):99. doi: 10.1186/s12904-023-01188-3. PMID: 37474943; PMCID: PMC10357741

Selected by:

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Presented by:

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Summary of Key Points

Physiotherapy is often utilized in palliative care units however its effectiveness on patient outcomes has not been definitively established. This is a Spanish study that looked at the Barthel Index, Functional Ambulation Categories, PPS and Braden Scale as a marker of physiotherapy effectiveness.

Summary of other key content in paper

PT did indeed improve patient functionality, independence and skills for ADLs.

Additional thoughts

Supports physiotherapist integration into PCU.

Physiotherapy applied to palliative care patients: a descriptive practice-based study. BMC Palliat Care

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Selected by:

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Why is this important?

Physiotherapy is essential in a palliative care unit, and this does provide some objective evidence as support.

Strengths

- Used several different scales.

Limitations

- Not very generalizable to non-malignant given study group.
- Relatively high PPS of participants.
- Does not encompass the other benefits physiotherapy provides – ex: hope.

Discussion

Honourable Mentions

1. Cohen MG, Althouse AD, Arnold RM, White D, Chu E, Rosenzweig M, Smith KJ, Schenker Y. **Primary Palliative Care Improves Uptake of Advance Care Planning Among Patients With Advanced Cancers.** J Natl Compr Canc Netw. 2023 Apr;21(4):383-390. doi: 10.6004/jnccn.2023.7002. PMID: 37015338. Adir
2. Gainza-Miranda D, Sanz-Peces EM, Varela Cerdeira M, Prados Sanchez C, Alonso-Babarro A. **Effectiveness of the integration of a palliative care team in the follow-up of patients with advanced chronic obstructive pulmonary disease: The home obstructive lung disease study.** Heart Lung. 2023 Aug 7;62:186-192. doi: 10.1016/j.hrtlng.2023.07.006. Epub ahead of print. PMID: 37556860. Jose
3. Chow JK, Pickens ND, Fletcher T, Bowyer P, Thompson M. **Missed Opportunities to Ease Suffering: An Explanatory Model of Occupational Therapy Utilization in End-of-Life Care.** Am J Hosp Palliat Care. 2023 Sep;40(9):1004-1012. doi: 10.1177/10499091221143917. Epub 2022 Dec 5. PMID: 36469746 Aynharan
4. Sedney CL, Dekeseredy P, Singh SA, Holbein M. **Stigmatizing Language Expressed Towards Individuals With Current or Previous OUD Who Have Pain and Cancer: A Qualitative Study.** J Pain Symptom Manage. 2023 Jun;65(6):553-561. doi: 10.1016/j.jpainsymman.2023.02.007. Epub 2023 Feb 15. PMID: 36804424. Jean
5. Grossman CH, Hearn R, McPhee M, Fisher F, Wools C, Mathers S. **Neuropalliative care for progressive neurological diseases: A scoping review on models of care and priorities for future research.** Palliative Medicine. 2023;37(7):959-974. doi:10.1177/02692163231175696 Leonie

Wrap-up

- Please fill out our feedback survey- a link will come up in your browser after this webinar ends.
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- Recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.
- To listen to this session and previous sessions, check out the **Palliative Care Journal Watch** podcast.
- We hope to see you at our next session!



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Thank You



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