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**Questionnaire Webform Results**

**For what line of therapy do you generally prescribe AVOSTERIN®?**

- **62.5%** for Pre-chemotherapy
- **50.0%** for First line post-chemotherapy
- **12.5%** for Second line post-chemotherapy

**Please give your rating for the following questions, on a scale of 1 to 5, where 1=poor and 5=excellent:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Your knowledge of the role of chemotherapy in the pathophysiology of mCRC</th>
<th>What is your current knowledge level of treatment options for mCRC?</th>
<th>What is your current knowledge level of treatment options for CRC at first metastases?</th>
<th>What is your current knowledge level of treatment options for CRC prior to docetaxel?</th>
<th>What is your current level of comfort with the role of prednisone?</th>
<th>What is your current level of comfort with symptom management in CRC?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor 1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Doctor 2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Doctor 3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Doctor 4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Approximately what percentage of mCRC patients in your region are referred on to a medical oncologist?

- >80%: 25.0%
- 1-20%: 50.0%
- 41-60%: 25.0%

What other agents do you prescribe for a large number of your mCRC patients and why?

<table>
<thead>
<tr>
<th>Name</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor 1</td>
<td>Consequat do labore magnam mollitia, eaque, quo. Quibusdam blandit nihil mattis senectus dignissimos ea risus consequatur aute, quo eros rem, nemo aliquid, amet nonummy placeat.</td>
</tr>
<tr>
<td>Doctor 2</td>
<td>Quibusdam blandit nihil mattis senectus dignissimos ea risus consequatur aute, quo eros rem, nemo aliquid, amet nonummy placeat, a platea congue sollicitudin, lorem dictum ea dicta facilisis, mattis vehicula. Tristique veniam, vel. Molestias architecto qui molestie dui pulvinar.</td>
</tr>
<tr>
<td>Doctor 3</td>
<td>Consequat do labore magnam mollitia, eaque, quo. Quibusdam blandit nihil mattis senectus dignissimos ea risus consequatur aute, quo eros rem, nemo aliquid, amet nonummy placeat, a platea congue sollicitudin, lorem dictum ea dicta facilisis, mattis vehicula. Tristique veniam, vel. Molestias architecto qui molestie dui pulvinar.</td>
</tr>
<tr>
<td>Doctor 4</td>
<td>Eaque nisl, voluptatem nonummy beatae, laboriosam saspe deleniti sagittis ait, nemo ante, erat urna! Eleifend metus voluptatum maiores, elementum, luctus iste at curae, molestias expicabo, explicabo facilisi justo, quia temporibus.</td>
</tr>
</tbody>
</table>
Please indicate anything that you are hoping to gain through this process (select all that applies):

- Insight into mCRC: 57.1%
- Insight into AVOSTERIN®: 28.6%
- Insight into the company: 14.3%

<table>
<thead>
<tr>
<th>Name</th>
<th>Do you have any specific questions you would like to ask the company with regards to their leadership role in Colorectal Cancer?</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor 1</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Doctor 2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Doctor 4</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Discussion Forum Transcript Summary

Section 1

Question 1

What customer needs do you believe this program will address? Do you think this program will enhance the discussions that you are currently having with your customers? Why or why not?

Question 1 Comments

**Jane Doe:** Customer Needs this will address: potentially offer new perspective on combination therapies based on individual patient, degree of hyperglycemia, cost, coverage, other patient characteristics that require consideration for unique treatment approaches and individualization. I believe there is some room for an enhanced discussion with specialists, from a Company123 perspective we can discuss more in-depth patient management such as self-monitoring strategies, etc...although the first episode won't be anything really net “new” for the general endocrinologist community....I would leverage this as a "unique and continuous self-learning opportunity from diabetes experts/colleagues"

**John Doe:** This will potentially offer new perspective on combination therapies based on individual patient, degree of hyperglycemia, cost, coverage, other patient characteristics that require consideration for unique treatment approaches and individualization.

Question 2

As a way to make things more convenient for family member interpreters, the use of technology such as “Face Time” and “Skype” are potential cost savers.

Would you or your colleagues ever consider these as viable options in your practice? Please explain why or why not? Please describe all the advantages and disadvantages of this as a potential solution.

Question 2 Comments

**Jane Doe:** In some instances, patients are already requesting this approach. There have been family meetings, in which patients have asked that their family members be available through speakerphone or FaceTime through patients' own cell phones.
**John Doe:** We would certainly consider this. A colleague in the U.S.A. years ago had a cassette tape recorded family discussion altered misrepresenting what the doctor said, and media formats vulnerable to digital manipulation remain a legal concern unless we also record a version for our records (which we cannot now do). I prefer speakerphone (landline) for now and in-person discussions with relative(s) present particularly for 1st or important discussions.

**John Smith:** These definitely should be considered, however they assume that the patient and/or family members have a level of comfort with the technology. This is generally a safe assumption for much of the population, but perhaps less for a demographic that does not speak English or may be older.

In this case, you are only adding to the stress of the encounter and the technology itself becomes a barrier to communication.

**Section 2**

**Question 3**

What customer needs do you believe this program will address? Do you think this program will enhance the discussions that you are currently having with your customers? Why or why not?

**Question 3 Comments**

**Jane Doe:** Yes, I would agree that language barrier pose as an added challenge to providing optimal health care. There may be a greater risk of miscommunication and misunderstandings. Not only can the clinical assessment take longer, some patients may request family members to take time off from school or work to accompany them for medical appointments. Thereby, there may be greater time commitments required of the patients and family members. Greater costs may arise from the increased use of hospital interpreter services.

**John Doe:** Language barriers affect my practice. Cost: It takes 3x the amount of time to get the required information and to transmit briefer versions of my education/treatment plan to the patient, affecting the flow of clinic, other patients and families. This can affect the patient’s insight, compliance, decisions about therapy, and anxiety level. A patient may make an uniformed decision (often the wrong one) without realizing the ramifications.

**John Smith:** Yes, language is a barrier in a variety of situations:

1. Reduced self-efficacy, leading to not making appointments when you’re sick or waiting until a translator is available. This means missed appointments or appointments not made. This leads to potentially poorer outcomes.
2. Certainly, longer visits and more uncertainty is also a problem which leads to greater costs.
3. Untrained and non-competent interpretation is also a big issue.
I know of one situation where a patient has cancer and is not able to speak English. She has many appointments with a variety of doctors and organizations and those appointments cannot be easily rescheduled or be scheduled at a time when her family members can attend with her. So, she has a neighbor go as a translator for her to all her appointments. The neighbor is home because she is disabled, but sometimes has her own medical issues to contend with. It is definitely a situation that causes difficulty for all involved.

**Question 4**

What tools, resources and processes do you normally use to manage patients who have limited proficiency in English in your clinical practice?

**Question 4 Comments**

**Jane Doe:**
1. A quiet environment
2. Family members or caregivers who are more proficient in the language
3. Clinicians who are aware of health literacy and who use plain language to communicate
4. Modules, images and teaching material that is highly visual and that contains limited text.

**John Doe:** We mostly use family members but ask directed questions 1 or 2 at a time and await answers, ensuring from body and facial language that the translator is faithfully and correctly passing on our discussion. If not, due to cultural issues, fear of making the pt anxious (etc.) we will use a translator from our very multicultural hospital staff or a toll-free # in the USA where translators for almost every language are available on speaker phone, funded by our hospital.

**John Smith:** In family practice, most of the time it is a family member or whoever the patient brings to the clinic with them. There is generally not enough time to find someone who can translate faithfully. In many cases, faith communities or ethnic communities have volunteers who will attend with patients for particularly important appointments, but it is hit and miss.

The other method I have used is to refer the patient to services in their own language. For example, mental health services can be provided at specialized mental health centres for patients in their own language. This only works in large urban centres where people of a particular language group live in large concentrations.

Sometimes brochures can be found on the web, but that is difficult as the quality of the written material is not always known.