# HOT SPOT

The Newsletter of the Rapid Response Radiotherapy Program
of the Odette Cancer Centre

Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

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## Editorial

**By Dr. Edward Chow, Editor**

Time flies and autumn is here. Our practice is busy again and Christmas holidays are approaching very soon.

This issue, Dr. Sally Bean discusses "Mitigating health care communication barriers: A legal, ethical and economic case for professional medical interpreters". Ms. Rosie Benson et al. explains in detail "The multi-dimensional role of the clinical nutrition team at the Odette Cancer Centre". Dr. Carlo DeAngelis outlines "Opioid-induced hyperalgesia: When more is less". Ms. Lisa Seto et al. shares with us her doctoral thesis on "Palliative end-of-life home care and Chinese immigrants: The meaning of home and negotiations of care". Dr. Michele Chaban highlights "Having and getting more life", in particular the recent landmark publication in the *New England Journal of Medicine* about the additional benefits of palliative care to oncology treatment. Dr. Ewa Szumacher provides the update on the continuing medical education.

We have four inserts this time: 1) Cancer-associated venous thromboembolism NCCN clinical practice guidelines—Update 2010 by Dr. Richard Jay, 2) HER2 testing and Trastuzumab in advanced gastric and gastroesophageal cancer by Drs. Eugene Hsieh and Yoo-Joung Ko, 3) Treatment of chronic lymphocytic leukemia in the elderly by Dr. Matthew Cheung, and 4) Systemic therapy for metastatic Renal Cell Carcinoma (mRCC) by Drs. Sonal Gandhi and Georg A. Bjarnason.

We hope all these are useful resources to our readers.

## Mitigating health care communication barriers: A legal, ethical and economic case for professional medical interpreters

**By Sally Bean, JD, MA**

The Greater Toronto Area (GTA) is a heterogeneous community consisting of a mosaic of languages, religions, races, ethnicities and cultures. According to the Toronto Central Local Health Integration Network (LHIN) demographic data from the 2006 census, 5% of those living within the LHIN have no knowledge or understanding of either of Canada's two official languages, English or French, and 41% of the population is immigrants with 8% of immigrants settling in the GTA within the past five years (Toronto Central LHIN, 2006). A recent article in the *Canadian Medical Association Journal* demonstrated that at their time of arrival in Canada, new immigrants are healthier than their Canadian counterparts. However, this "healthy immigrant effect" is limited with an increased self-reported risk of poor health among immigrants with limited English- or French-language proficiency (Pottie, Tugwell, Feightner et al., 2010). Two-way communication is a fundamental part of health care delivery, so it is not surprising that communication barriers negatively affect

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### In this issue of HOT SPOT:

# Mitigating health care communication barriers: A legal, ethical and economic case for professional medical interpreters

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access and quality of health care services for anyone facing communication barriers. One reliable way to alleviate communication barriers is through the use of professional medical interpreters to facilitate health care delivery. A professional medical interpreter is an individual who has been trained and assessed for professional medical interpretation skills, demonstrates a high level of proficiency in at least two languages, and abides by national standards of practice, professional code of ethics, applicable legislation and a health care institution's applicable policies. In contrast, informal or *ad hoc* interpreters are persons self-identified as able to interpret conversationally into one or more languages, but lack the linguistic skills and certification that would be acquired from professional interpreter training. In hospitals, informal interpreters would be family and friends of non/limited English-speaking or deaf patients, and hospital staff that speak various languages.

Accessibility is one of five criteria outlined in the *Canada Health Act* promulgated with the intent of ensuring that residents of Canada have access to insured health services on consistent terms and conditions. In addition to the accessibility criterion, there are numerous legal, economic and ethical arguments to support the provision of professional medical interpretation services in a respectful and culturally appropriate manner. The *Canadian Charter*, *Ontario Human Rights Code*, privacy legislation, *Accessibility for Ontarians with Disability Act*, *Health Care Consent Act* and applicable case law all lend legal support for access to professional medical interpreters. Ethical justification for mitigating communication barriers through the use of professional medical interpreters enables patient autonomy through informed decision-making, respect for person's privacy, justice and fairness through equitable access to health care resources, quality patient care and alignment of organizational and health care providers' actions with the health care institution's mission, vision and values. Numerous economic justifications exist for using professional medical interpreters such as reducing adverse events, shortening length of stay and minimizing inappropriate use of testing and procedures. Empirical research indicates that language barriers can compromise a clinician's ability to elicit patient symptoms, which leads to diagnostic errors (Hyman 2009). Use of professional medical interpreters to obtain a proper patient history eliminates reliance on inappropriate diagnostics that can increase cost and impede patient flow (Hyman, 2009). Finally, a 2004 University Health Network retrospective study revealed that patients with a language barrier had a longer length of stay for seven of 23 examined conditions and overall 6% (approximately .5 days) longer relative to patients without a language barrier (Hyman, 2009).

The legal, ethical and economic arguments for mitigating communication barriers through use of professional medical interpreters are compelling. However, many clinicians still struggle with when to seek the services of professional medical interpreters. The following recommendations should help inform that decision-making process, but health care providers should always refer to applicable institutional policies and governing law:

- Health care providers should assess patients and, where indicated, take appropriate steps to ensure that a patient's communication barriers do not interfere with that person's medical care.
    - One way to accomplish this is by simply asking if the patient prefers to communicate in a language not spoken by the clinician.
    - At a minimum, key discussions where a patient's legal rights or status might be affected, such as informed consent discussions, capacity assessments, discharge planning and adverse event disclosure, should use professional medical interpreters.
- The preference is for face-to-face professional medical interpretation where available. Remote interpretation through the telephone or video-conferencing are possible alternatives when face-to-face interpretation is not feasible.
- *Ad hoc* interpreters are not used unless in an emergency situation.
- Interpretation is provided in a timely manner that is culturally sensitive and appropriate.
- The interpretation encounter should be documented in the patient's chart. Documentation should include the patient's primary language, full name of the interpreter and general facts of the interpreted dialogue.

These recommendations provide only a cursory overview of health care provider considerations, but are intended as a catalyst for improvement. Health care provider education and awareness of the negative impacts of communication barriers and how they can be mitigated through the use of professional medical interpreters is an important step toward improvement.

## References

Hyman, I. (2009, June). Literature review: The costs of not providing interpretation in healthcare. *Access Alliance Publication LR004*.

Pottie, K., Tugwell, P., Feightner, J., et al. (2010). Summary of clinical preventive care recommendations for newly arriving immigrants and refugees to Canada. *CMAJ,* DOI:10.1503/cmaj.090313

Toronto Central LHIN. (2008). *Diversity at a Glance: Neighborhood Area 4 North Central*. Retrieved from http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Fact_Sheet/4-North%20Central%20-%20Midtown,%20Leaside,%20North%20Riverdale,%20Forest%20Hill.pdf

# The multi-dimensional role of the clinical nutrition team at the Odette Cancer Centre

**By Rosie Benson, NT, Elaine Posluns, RD, Tracey Rapier, RD, Edith Stokes, RD, and Pauline Wisdom-Gilliam, RD**

A comprehensive nutritional program can benefit every area of patient care within an oncology program. The clinical nutrition team includes registered dietitians and a nutrition technician who play an important role in providing care across the cancer continuum, from prevention to palliation. The registered dietitian screens and assesses new patients, then develops patient-centred nutrition care goals based on findings, and formulates individualized nutrition care plans. The nutrition team disseminates nutrition information to patients, families and the public, and educates health care professionals and nutrition students.

In the Patient and Family Support Nutrition Resource Centre, the nutrition technician answers general nutrition questions and provides nutritional supplement samples. The technician also conducts patient triage by screening and referring patients to the appropriate dietitian. Once assessed, the dietitian works with patients on strategies to correct nutritional deficiencies, maintain weight, and improve the patient's nutritional status during treatment and recovery. With disease progression, nutritional intervention increasingly focuses on ensuring optimal quality of life through symptom management and prevention of further complications. Maintaining energy and strength through adequate nutritional intake directly affects a patient's ability to perform the activities of daily living and to function independently for as long as possible.

Timely referral to the clinical nutrition service is important in ensuring that patients receive optimal nutritional care.

As treatments and side effects differ for each cancer patient, so do nutritional needs. The clinical nutrition team can help with:

- nutrition questions about healthy eating before, during and after treatment, vitamin and mineral supplementation, bone health
- any problems or side effects that limit intake, such as swallowing difficulty, nausea and vomiting, diarrhea, constipation or other digestive problems
- healthy body weight
- advice about herbals, complementary therapies
- food safety during treatment
- selection of appropriate nutritional supplements
- enteral feeding.

## Why choose a dietitian for your nutritional advice?

Dietitians in Ontario are uniquely trained food and nutrition experts. They have a nutritional sciences degree and have completed a post-graduate dietetic internship. They are the recognized experts in translating scientific, medical and nutrition information into practical individualized therapeutic diets, healthy meal plans for people, and building the capacity of individuals and communities to access nutrition for health and wellbeing. The nutrition technician has graduated from a two-year college program and completed an internship certification in Food and Nutrition Management.

# Palliative end-of-life home care and Chinese immigrants: The meaning of home and negotiations of care

**By Lisa Seto, PhD(c), Jan Angus, PhD, Doris Howell, PhD, Denise Gastaldo, PhD, and Amna Husain, MD**

Chinese immigrants make up one of the largest minority groups in the country, yet little is known about what happens after they are diagnosed with advanced cancer and sent home to receive palliative care. Often, immigrants must negotiate multiple meanings of home: home as a place of origin, a form of shelter, and a place of belonging. For Chinese immigrants, dealing with terminal illness may be layered and intimately connected with the meaning of home, experiences of migration, and efforts to create a sense of belonging in Canadian society. However, receipt of palliative home care can shift the meaning of home, as multiple health care providers may come through the home to provide palliative and supportive care.

The purpose of this research study is to gain a better understanding of how Chinese immigrants with advanced cancer, their family caregivers, and home care providers negotiate the work and meaning of palliative home care with each other. This study is particularly focused on looking at how experiences of migration and meanings of home shape these negotiations and influence palliative end-of-life care in the home. Recruitment has started at the Temmy Latner Centre for Palliative Care and the Toronto Central and Central Community Care Access Centres in conjunction with home care agencies: S.R.T. Med-Staff and Saint Elizabeth Health Care. Participants will be recruited from the Greater Toronto Area.

This qualitative ethnographic study includes preliminary interviews with key informants such as home care nurses, personal support workers, case managers, and palliative physicians. In addition, five households will be recruited, each consisting of a Chinese immigrant with advanced cancer, family caregiver, and home care provider. Direct observations of care will be conducted at the homes of participants over several visits, and interviews will be conducted with each participant about their experiences with palliative home care. The study will contribute to an understanding of the

Collaboration with clients, caregivers, and other health professionals is central to dietetic practice whether the dietitian works in a private practice or as a member of a health care team.

Dietitians are members of the College of Dietitians of Ontario and practice according to the Code of Ethics and Professional Misconduct Regulation. Anyone can call themselves a nutritionist and legally provide nutrition advice. What sets dietitians apart is their academic and professional training and their accountability to a regulated college that ensures safe, competent and ethical practice of dietitians in the interest of the public and public protection. Each dietitian must participate in quality assurance and practice assessment programs to ensure continuing competency.

Any health care clinician may refer patients or caregivers to see a dietitian. Patients may also self-refer by calling 416-480-4623 or by dropping by the Patient and Family Support Nutrition Resource Centre located on the ground floor of the Odette Cancer Centre.

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palliative home care experiences of Chinese immigrants with advanced cancer, and provide a rich description of the concerns, needs, and supports Chinese immigrant families may encounter in the community. It is important to examine the palliative home care experiences of Chinese immigrant families to understand how health care providers can better support death and dying with dignity in the home.

This research study is part of a doctoral thesis at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. If you have any questions, please contact Lisa Seto, RN, PhD Candidate at (416) 978-1578 or **lisa.seto@utoronto.ca**.

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# Having and getting more life

**By Michele Chaban, MSW, RSW, PhD**

In August 2010, in the *New England Journal of Medicine*, a most remarkable study was published. The study followed 151 lung cancer patients with fast-growing disease over the course of three years. Patients were randomly assigned to either oncology treatment alone or oncology treatment with palliative care, pain relief and other measures intended to improve a patient's quality of life.

From the point of diagnosis, those getting palliative care reported less depression and happier lives, as measured on scales for pain, nausea, mobility, worry and other issues. Fully informed of their options for care, fewer of those studied opted for aggressive chemotherapy as their illnesses worsened and many left instructions that they did not want to be resuscitated in a crisis. The research found that people who received palliative care lived nearly three months longer than their peers who did not receive palliative care.

Living three months longer may or may not be a good thing. After all, who wants to live longer if those days and months are spent in suffering, with a poor quality of life? The research study allays these fears. Those receiving palliative care immediately upon diagnosis were happier, more mobile and in less pain as the end neared. According to this study, both the quality and the quantity of life were enhanced for these patients, by accessing H/P/EOLC. Access meant everyone had time to deal with the suffering over months, rather than a timeframe of hours to days.

Why did those who had early and timely access to palliative care live longer? Perhaps it was because they surrounded themselves with people who helped them preserve their life rather than simply sustain and extend it. They surrounded themselves with those who helped them attend to, rather than avoid and deny their suffering.

How does attending to suffering extend life? It is known that depression shortens life, and patients whose pain is treated often sleep better, eat better and talk more with relatives.

Dr. R. Sean Morrison, president of the American Academy of Hospice and Palliative Medicine, said this study was the "first concrete evidence of what a lot of us have seen in our practices—when you control pain and other symptoms, people not only feel better, they live longer." In Canada, Senator Carstairs, a champion of H/P EOLC has recently released a report speaking to the need for more attention to end-of-life suffering (http://sen.parl.gc.ca/scarstairs/PalliativeCare/Raising%20the%20Bar%20June%202010%20(2).pdf).

The *New England Journal of Medicine* study suggests that longevity, happiness and less evident levels of health can be achieved as we are dying. It would seem the research, as well as the anecdotal evidence, is pointing to our attending clearly and overtly to all aspects of suffering in an individual and his or her family with H/P/EOLC in conjunction with anti-disease therapies as needed.

Shall we seek longevity through anti-disease therapies alone and the suffering that often accompanies these goals? Or shall we ask for the person-centred, integrated, inter-professional model of care that many of us have sought for decades, knowing that it creates healthier, happier individuals and families, greater longevity than anti-disease treatment alone? The choice is ours to make and ours to voice, but unless we make our voice heard, our children and our friends will find themselves frustrated by their ability to help us heal as we are dying.

## About the author

*Dr. Michele Chaban is the Director of the Inter-professional Applied Mindfulness Meditation Program (AMM) at University of Toronto, Factor-Inwentash School of Social Work, cross-appointed to the Department of Family and Community Medicine, the Dalla Lana School of Public Health and the Centre for Bioethics. She also is Director of the Contemplative End of Life Care Program, Institute of Traditional Medicine. Michele is in private clinical practice with a host of inter-professional colleagues (**habitathealing.com**).*

# Opioid-induced hyperalgesia: When more is less

**By Carlo DeAngelis, PharmD, Clinical Pharmacy Coordinator—Oncology,
Department of Pharmacy, Odette Cancer Centre, Sunnybrook Health Sciences Centre**

One of the cornerstones of effective use of opioids in pain management is the titration of opioid dose and optimization of schedule until satisfactory pain relief is achieved or side effects prevent further dose escalation (Hanks, de Conno, Cherry, et al, 2001). However, all clinicians have been faced with the situation of poor pain control despite increasing doses of opioids. Recent research, particularly in animal models, is beginning to provide insight into the causes of this phenomenon, as well as direct possible clinical management strategies for these patients.

Opioid-induced hyperalgesia (OIH) is a paradoxical response to an opioid agonist. It differs from tolerance in that rather than improving pain control, an increase in opioid dose actually worsens the patient's pain experience (Colvin & Fallon, 2010). While there is much debate as to how to diagnose or recognize OIH and its true clinical significance, when it does occur it does complicate the pain management of a patient. In addition, the current emphasis on monitoring for opioid addiction or diversion creates a potential situation where OIH may be dismissed as a possible cause for a patient's poor response to opioids.

Clinicians experienced in the use of opioids are very familiar with the occurrence of tolerance to the analgesic effects of the opioids. While neurological changes in pain transmission pathways leading to tolerance must be present for OIH to occur, the converse is not true. The neurobiology of OIH has been extensively studied in animal models and while not completely understood, involves both peripheral and central changes in pain transmission and perception pathways (Colvin & Fallon, 2010; Silverman, 2009). While the N-methyl-D-aspartate (NMDA) receptor is thought to play a significant role in OIH, other receptors and neurotransmitters such as 5-HT$_3$, 5-HT$_2$, NK-1, opioid, TRPV1 receptors, and endogenous cholecystokinin, Substance P, dynorphin, IL-1b, IL-6, TNFa, as well as genetic predisposition also contribute to the development OIH (Colvin & Fallon, 2010).

Clinically, the diagnosis of OIH is a challenge as not only must it be distinguished from tolerance, but also from increased pain associated with disease progression. Thus, when faced with a patient with increasing or poorly controlled pain, there are some basic clinical considerations that may help the clinician identify OIH. Ruling out disease progression as a cause for an increase in the patient's pain is vital. An additional consideration is increased pain associated with increased activity. These two scenarios require the optimization of opioid dose and schedule and are, therefore, managed in a fundamentally different way than OIH. If the increase in pain intensity is associated with development of tolerance, then an increase in opioid dose will lead to an improvement in pain control. Clinically OIH is typically described by patients as being more diffuse and associated with areas other than their original pain location. OIH may also be associated with excitatory side effects of opioids such as agitation, confusion, delirium, myoclonic activity and in extreme case seizures. The pain of OIH is often described as being similar to the pain associated with opioid withdrawal with the difference being that an increase in opioid dose ameliorates the latter situation.

Despite the fact that much of the data related to management of OIH is empirical, several treatment strategies have been suggested (Colvin & Fallon, 2010; Silverman, 2009). These include:

- Use of opioid sparing adjunctive therapies including a tricyclic antidepressant or anticonvulsant agent (gabapentin)
- Opioid rotation
- Opioid dose reduction
- Adjunctive NMDA receptor antagonist therapy (ketamine, low dose methadone)
- Use of an opioid with agonist/antagonist properties.

While many questions remain regarding the diagnosis and management of OIH, it is important for the clinician to consider the possibility of OIH in the differential diagnosis of a patient who presents with increasing pain intensity despite escalating doses of opioid.

## References

Colvin, L.A., & Fallon, M.T. (2010). Opioid-induced hyperalgesia: A clinical challenge. *Br J Anaesth, 104*, 125–127.

Hanks, G.W., de Conno, F., Cherry, N., et al. (2001). Morphine and alternative opioids in cancer pain: The EAPC recommendations. *British Journal of Cancer, 84*, 587–593.

Silverman, S.M. (2009). Opioid induced hyperalgesia: Clinical implications for the pain practitioner. *Pain Physician, 12*, 679–684.

# Continuing Medical Education 2010–2011

**By Ewa Szumacher, MD, MEd, FRCP(C)**

Continuing Medical Education (CME) can update health care professionals on the latest advances for modifications to their clinical practice. At the request of the CME organizers, Hot Spot will list the national and international CME activities in palliative medicine that are of interest to our readers. Please forward details of the CME activities to: **Ewa.Szumacher@sunnybrook.ca**

- **November 8–10, 2010**
  7th Global Conference—Making Sense of: Dying and Death: Care, Dying and the End of Life, Prague, Czech Republic
  **http://www.inter-disciplinary.net/probing-the-boundaries/making-sense-of/dying-and-death/details/**

- **November 11–14, 2010**
  The First International Multidisciplinary Forum on Palliative Care, Budapest, Hungary
  **http://www.imfpc.org/**

- **November 20, 2010**
  15th Annual Conference: Science & Art of Pain and Symptom Management, Toronto, Canada
  **https://events.cepdtoronto.ca/website/index/FCM1004**

- **November 25–27, 2010**
  48th Ontario College of Family Physicians Annual Scientific Meeting, Toronto, Canada
  **http://www.ocfp.on.ca/english/OCFP/annual%20scientific%20assembly/default.asp?s=1**

- **February 10–12, 2011**
  Musculoskeletal disorders and Chronic Pain Conference, Los Angeles, CA
  **http://www.cirpd.org/conference2011/content/home.cfm?CFID=224978&CFTOKEN=26756063**

- **March 21, 2011**
  6th Educational Conference on Palliative & End of Life Care: Dying in Old Age: Context and Community, Toronto, Canada
  **http://www.careconferences.com/**

- **May 19–21, 2011**
  30th Annual Scientific Meeting of the American Pain Society, Austin, TX
  **http://www.ampainsoc.org/meeting/annual_11/**

- **May 19–21, 2011**
  12th Congress of the European Association for Palliative Care, Lisbon, Portugal
  **http://www.eapcnet.org/Lisbon2011/**

- **June 3–7, 2011**
  47th American Society of Clinical Oncology (ASCO) Annual Meeting, Chicago, Ill
  **http://chicago2011.asco.org/**

- **June 21–25, 2011**
  9th International Conference on Grief and Bereavement in Contemporary Society and Association for Death Education and Counseling 33rd Annual Conference, Miami, FL
  **http://www.adec.org/conf/**

## Correction

The website for the article “Providing person-centred cancer care” from the May issue of Hot Spot should be: **http://www.partnershipagainstcancer.ca/**
We apologize for the error.

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