# 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. May Tsao, MD, FRCPC**

In this issue of **Hot Spot**, Dr. Shear's summary insert provides an overview of cutaneous T-cell lymphoma and Dr. Weinberg's on meeting the challenges of opioid-induced constipation. Shannon Furey's article deals with motivational interviewing as a tool for smoking cessation. The ethical issues regarding delayed disclosure are discussed by Dr. Hébert. Dr. Ma et al.'s article deals with perspectives about communication with health care providers. Dr. Vachon discusses spirituality in advanced cancer. In addition, Dr. Szumacher provides a list of upcoming CME activities. We thank all our contributors and hope you find this issue of **Hot Spot** both interesting and useful.

## Hot Spot congratulates Dr. Andrew Smith on his appointment as the new Chief, Odette Cancer Centre and Regional Vice-President, Cancer Care Ontario

Dr. Smith is a graduate of the medical school at the Faculty of Medicine, University of Toronto. He then completed a Master of Science at the University of Toronto, at the Samuel Lunenfield Institute, while also completing his postgraduate training in General Surgery. Following a surgical oncology fellowship at Memorial Sloan-Kettering Cancer Center, he returned to Sunnybrook as a staff surgical oncologist in 1999. In 2003, he assumed the role of Division Head, General Surgery, at Sunnybrook. He was promoted to Associate Professor in the Department of Surgery in 2005. His leadership skills were recognized when he was selected as the Langer Chair of the Division of General Surgery at the University of Toronto in 2009. Since October 2010, he has served as the Interim Chief of the Odette Cancer Centre and the Interim Regional Vice-President, Cancer Care Ontario.

Dr. Smith has established himself as a leader in the management of colorectal cancer in Canada. He also has more than 50 peer-reviewed publications on a range of topics from early events in colorectal tumourigenesis to various aspects of knowledge translation. He has also lectured extensively locally, regionally

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### In this issue of Hot Spot:

## Dr. Andrew Smith, Chief, Odette Cancer Centre and Regional Vice-President, Cancer Care Ontario

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and internationally. His excellence as a teacher has been recognized numerous times over the years, including the Dr. A.W. Harrison Resident Teaching Award at Sunnybrook (1996), the Davis and Geck Award of the University Division of General Surgery (1997), and the Peters-Boyd Academy Award for Continuing Education (2003). His contributions to knowledge translation and quality improvement have been recognized with the OHA Innovation in Clinical Practice Award (2005) and the Cancer Care Ontario CQCO Quality Innovation Award (2006). Dr. Smith's multifaceted accomplishments have also garnered for him the Marvin Tile Distinguished Service Award from the Sunnybrook Department of Surgery (2007) and the James IV Association Traveling Fellowship (Canada) for 2009.

# Motivational interviewing as a tool for smoking cessation intervention in the oncology setting

**By Shannon Furey, MSW, RSW, Tobacco Treatment Specialist**

In 2009, the Canadian Tobacco Use and Monitoring Survey reported that 18% of Canadians over the age of 15 were tobacco users. The importance of stopping smoking must not be overlooked, especially for those patients diagnosed with, being treated for, or surviving cancer (Grtiz, Fingeret, Vidrine, Mehta, & Reece, 2005). Furthermore, plenty of evidence has shown that continued tobacco use has an impact on effectiveness of treatment, survival, risk of second primary malignancy and, especially, quality of life (Bastian, 2011).

Many health care providers struggle with the challenge of providing assistance to those who show resistance or ambivalence towards quitting smoking. Working at the Odette Cancer Centre, I have observed the challenges that health care providers face when speaking to their patients about tobacco use. I believe that conversations regarding tobacco use in the oncology setting are challenging for a number of reasons.

There are a multitude of approaches for working with nicotine addiction. As a Smoking Cessation Counsellor, I have found the principles of motivational interviewing (MI) to work very well with a patient-centred approach to care. This widely utilized approach emphasizes the following principles: avoiding arguing, expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy (Rollenick, Miller, & Buttler, 2007).

The following example illustrates MI utilization with an individual who was newly diagnosed with cancer.

After being asked about tobacco use a patient comments, "I would like to quit smoking, but I can't right now because I am too stressed."

Instinctively, many clinicians would be compelled to point out the stress that will result from continued tobacco use. However, what would be most helpful in this situation would be to reflect the individual's feelings and empathize with their situation. You might say: "I understand that this must be a difficult time for you, it sounds like you are stressed." By reflecting with the patients, you may have an opportunity to build rapport with them and have them see that you are empathetic to the challenges of nicotine addiction.

On a daily basis, I have been able to talk with patients in a way that allows them to share their individual experiences with tobacco. I believe that allowing individuals to share their stories about tobacco use can be a great way of opening up the lines of communication regarding nicotine addiction and one's thoughts about quitting. Tobacco use can have a profound psychological impact. Some individuals develop an emotional attachment to their tobacco use; this attachment to tobacco use can be due to a number of reasons. As we work with patients to explore their willingness to quit tobacco, it is important to be respectful regarding the depth of emotional connection that can be associated with long-term use of tobacco, and memories about the beginning of one's relationship with tobacco.

When approaching the subject of nicotine addiction in the oncology setting, the psychological connections are often under-appreciated. Understanding patient connection to tobacco use and the range of feelings associated with quitting tobacco use are important aspects of providing effective smoking cessation counselling. Many approaches have proven to be effective for working with nicotine addiction. Motivational interviewing is believed by many to be the superior approach to counselling in this area. As we strive to provide an enhanced quality of care to patients in the oncology setting, I believe that most health care providers can challenge themselves to have a deeper appreciation for the psychological and emotional aspects of nicotine addiction. An approach that combines evidence-based pharmacotherapy and empathetic counselling should improve everyday intervention for nicotine addiction in the oncology setting.

## About the author

*Shannon was the Smoking Cessation Program Coordinator & Counsellor Sunnybrook Health Sciences Centre at the time of writing.*

# Disclosure delayed

**By Philip C. Hébert, MD, PhD**

In early 2005, an oncologist worried that a patient with hormone receptor negative lobular breast cancer since 2002 was not responding to conventional chemotherapy treatment. The patient's husband, a physician, sought medical advice in the U.S. That advice resulted in retesting the patient's hormone receptor status in the spring of 2005 and, unfortunately, it was discovered the original test result, done by Immuno-Chemical Histology (ICH), was errant. Newer testing revealed that the patient was, in fact, Hormone Receptor positive. This would obviously have had serious implications for her original treatment—had this been known, she would have been treated with anti-hormone therapy that would likely have put her into remission. By the time the error was uncovered, although she was treated with anti-estrogen therapy, it was too late and she died of advanced disease in August 2005.

The "conversion" of this patient's hormone receptor status was not, as it turns out, unique. It led to the retesting of hundreds of patients diagnosed with breast cancer. Of the 1,000 or so patients subsequently retested, one-third had not received appropriate care on account of faulty pathology testing. This is, of course, the errant breast hormone testing "incident" in Newfoundland that resulted in a prolonged inquiry and evidenced a profound mistrust of the Regional Health Authority. This incident can be considered a "large-scale adverse event"—a situation where many (in this case hundreds) of patients are harmed or potentially harmed.

One difficulty with such large-scale events is that one does not know, at the outset, how extensive the errors are. Is the affected patient the only one, or are there more cases? In the case of Newfoundland, after the incident case, 25 patients were quickly retested in June 2005—half converted, a surprisingly large number, which led to the efforts to retest all patients from 1997 to 2005. What was worrying to patients and the public is that information about the incident and who might be affected took an inordinately long time to come out. The first tack of health authorities was, it seems, to do the retesting in secret—perhaps out of concern that public panic might ensue. As a result, the news about how extensive the adverse incident might be did not come out until October 2005—and only then inadvertently, as a result of an off-hand remark by a health authority about another matter. So, the first knowledge that many affected people had of the problem was via the mass media. The delay in outright disclosure of the "lookback" that was going on only raised public anger and concern.

Transparency and openness about the lookback into the incident was not, it seems (and was seen by the public not to be), foremost in the minds of the minders. To many, it seemed the attitude of officials was one of "damage control," not how quickly one could get the word out to as many people as possible. The delay in public disclosure may have been done with the best of intentions—they may have been uncertain about how extensive the incident was, they wished not, perhaps, to worry the unaffected, no doubt they hoped to control the release of information. These explanations, in the cold light of day, seemed to be post-hoc rationalizations for dishonesty.

At least the word got out. Many equally inaccurate and harmful testing processes take place in medicine and we never hear of these. Lookbacks, if they occur at all, take place in secrecy. Apparently, one of the key underlying elements of this adverse event was the unreliability of the older form of IHC testing—something that has been known for years and that caused, on average, a false negative hormone receptor status testing rate of 30%! Unfortunately, this error rate was not uncommon in pathology and in other disciplines such as radiology. Without firm oversight and rigorous quality control programs, error and adverse events flourish.

Thus, at the time of the incident, surprisingly, Newfoundland's error rate was the "industry average." This seems like an industry that tolerated an error rate that no other industry would. Would the public and patients, if they had known this error rate, have been so sanguine as some officials had been?

What was clearly troubling was not so much the error rate—as bad as that was—it was that, once the frequency of errors in pathology was discovered, it was not immediately brought to the public view. One can understand some brief delay, but, after the authorities understood the scope of the problem, to wait months to go public only inflamed public concern: the problem was surely, it was felt, much bigger than the authorities were letting on. All health representatives were seen as tarred with the same brush: health authorities were covering up management ineptitude, doctors were hiding professional negligence, government representatives were trying to pass the buck to anyone else. No one, it seems, was willing to take responsibility for managing this event. The lack of initial transparency, coupled with the absence of any attempt at an early apology, was critical to the public outrage and to the calls for a commission of inquiry.

In this lies a lesson: when advances in medicine uncover the inaccuracies of previous practices—and especially when they may have harmed patients—serious and timely efforts must be undertaken with the public's input to understand the implications of the advances and to try to ensure this is disclosed to those who are, or may be, affected by trusted individuals within the patient's circle of care.

## About the author

*Philip C. Hébert, MD, PhD is a Professor in the Department of Family Medicine and Chair of the Research Ethics Board at Sunnybrook Health Sciences Centre.*

# Patients' perspectives about communication with health care providers

**By Grace Ma, MD, Christopher Obwanga, BSc, Amna Husain, MD**

Patients universally report that communication with their health care providers (HCP) is important to their care and well-being. Patients generally prefer face-to-face communication with their HCPs. However, patients recognize that not all communication requires face-to-face meetings, nor would it be feasible for HCPs to be available for face-to-face meetings for all communication and coordination needs. The use of electronic communication may enhance communication between HCPs and patients and their caregivers. While there is some information in the literature regarding email communication between patients and their HCPs (Katzen, Solan, & Dicker, 2005; Ye, Rust, Fry-Johnson, & Strothers, 2010; Zickmund, Hess, Bryce, et al., 2008), to our knowledge there are no studies investigating patients' perspectives on what aspects of communication patients find acceptable to manage with an online communication platform.

Our study aims to explore palliative care patients' views on what is important to them in communicating with their HCPs. We also aim to determine which aspects of communication would translate to an online communication tool. We will investigate what patients perceive as enablers and barriers to communication when using an online communication tool. Last, we will explore whether patients would endorse the use of a secure online communication tool. Recruitment has started at the Temmy Latner Centre for Palliative Care. Participants will be recruited from the Greater Toronto Area.

This qualitative study involves semi-structured interviews with patients and their caregivers. Preliminary data from the first few interviews show that patients and their caregivers are open to the idea of an online communication tool.

***Patient:*** *"I do not currently use email to contact my health care providers, but would be very interested in doing so… (There will be) reassurance and assurance in knowing that all my health care providers will be informed. I see the electronic tool as a 'time saver'. DNR (*Do Not Resuscitate, *information about advanced directives and preferences for care) should be available on the electronic application for all health care providers to see."*

***Caregiver:*** *"If all health care providers were networked (on the proposed application), I would use it as primary method of communication, (then I) don't have to run around and play tag."*

One preliminary theme is the idea that coordination of care is often left to patients and their caregivers.

***Caregiver:*** *"I think, too, the respirologist we see is outside of the hospital, so a few times he has not heard any information from the hospital and we have not either and so then J (patient) gets sent for another x-ray. That could be a bit more coordinated. We are trying to get that organized, we have sort of asked for reports to be sent to him."*

This research study is part of a scholarly project in the Palliative Medicine Residency Program, University of Toronto, under the supervision of Dr. Amna Husain. If you have any questions, please contact Dr. Grace Ma, PGY3 at **grace.ma@utoronto.ca**.

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# Spirituality in advanced cancer

**By Mary L.S. Vachon, PhD, RN**

As I recently celebrated my 14th anniversary of finishing chemotherapy for stage 4 NHL, I was conscious of my increased awareness of the importance of spirituality in the lives of many persons with cancer. I remember two clients with advancing disease. Both had tried many approaches to dealing with their cancer, now they were ready to deal with spiritual issues. In a meditative experience, a young man said, "I was held in the arms of God. He didn't tell me whether I was going to live or die, He just said that everything would be alright." A woman with advanced cancer used the Prayer Wheel (**www.theprayerwheel.com**). She asked that before she died she be able to have at least one "real" conversation with her mother who had been schizophrenic since the client was a young girl. After many months of praying for this intention she had a remarkable and totally lucid conversation with her mother. Both of these people died peacefully and "healed".

Mount, Boston and Cohen (2007) note that life-threatening illness is an assault on the whole person—physical, psychological, social and spiritual. It frequently presents caregiver and sufferer with a paradox—suffering does not correlate with physical well-being alone. The themes common to patients experiencing suffering and anguish "include a sense of isolation and of being disconnected." Analysis across cases when the participants experienced integrity and wholeness yielded strikingly different themes from those with suffering and anguish. "[T]hese individuals tended to find a sense of meaning and connectedness in the context of their illness. They also tended to experience a greater acceptance of their illness."

A consensus conference was held, based on the idea that spiritual care is a fundamental component of quality palliative care (Puchalski et al., 2009). Spirituality was defined as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred" (p. 887). Their recommendations included: that every patient's spiritual symptoms, values and beliefs be assessed and integrated into the plan of care; that all members of the team be trained in spiritual care; and that to provide such care, team members should have training in self-care, self reflection, contemplative practice, and spiritual self care.

There is a difference between religion and spirituality (R/S). In a multi-centre study, Alcorn et al. (2010) defined spirituality as "a search for or a connection to what is divine or sacred." Religion was defined as "a tradition of spiritual beliefs and practices shared by a group of people." Seventy-eight per cent of their sample found religion or spirituality to be important in their cancer experience. Younger, more religious, and more spiritual patients identified R/S concerns more frequently.

Several years ago, Vachon et al. surveyed persons at all stages of living with cancer in Manitoba, Quebec and Toronto. Three-quarters (1,060/1,414) used complementary and alternative approaches (CAM) to cope with their cancer. The most commonly used CAM approach was prayer (40%). Fifty-nine per cent of the Toronto group used prayer. In a group of 60 Toronto palliative care patients, 40 used complementary approaches to coping with their disease. Of these, 69% used spirituality as a way of coping with their disease and 69% used prayer. Respondents' perceptions of benefit from CAM use included: spiritual strength (33%), increased hope (29%), improved quality of life (27%), reduced stress and anxiety (16%), an improved sense of control (9%) and improved pain and symptom management (4%).

Balboni et al. (2010) surveyed 343 patients in multiple sites from baseline (116 days before death until their deaths). Sixty-eight per cent of the participants rated religiousness as being very important. Twenty-six per cent felt they were totally or to a large extent spiritually supported by the medical system. Forty-six per cent had received spiritual support from a member of the pastoral team in the hospital or clinic. Forty-three per cent felt totally or to a large extent supported by their personal religious community. Thirty-seven per cent had an end-of-life conversation with a physician. Patients whose spiritual needs or religious needs were largely or completely supported by the medical team received more hospice care in comparison with those not supported. Spiritual support from the medical team and pastoral care visits were associated with higher QOL scores near death.

## About the author

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# Continuing Medical Education 2011–2012

**By Ewa Szumacher, MD, 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**

- **May 14, 2011:** Society of Urologic Oncology 2011 Annual Meeting, District of Columbia/Washington, Oncology, Urology
  Website: **www.suonet.org**
- **May 22–24, 2011:** 2nd Global Conference–Making Sense of Pain, Warsaw, Poland
  Website: **www.inter-disciplinary.net/probing-the-boundaries/making-sense-of/pain/call-for-papers**
- **May 31–June 1, 2011:** New Frontiers in Persistent Pain, France/Paris, Pain Management
  Email: **events@abcam.com**
  Website: **www.abcam.com/index.html?pageconfig=resource&rid=12881**
- **June 3–7, 2011:** American Society of Clinical Oncology (ASCO) 2011 Annual Meeting, Illinois/Chicago, Oncology
  Website: **http://chicago2011.asco.org**
- **June 22–25, 2011:** 13th World Congress on Gastrointestinal Cancer, Spain/Barcelona, Gastroenterology, Oncology
  Email: **meetings@imedex.com**
  Website: **http://worldgicancer.com/wcgi/wgic2011/index.html**
- **July 3–7, 2011:** 14th World Conference on Lung Cancer, Netherlands/Amsterdam, Oncology.
  Email: **wclc2011@icsevents.com**
  Website: **http://2011worldlungcancer.org**
- **July 7–10, 2011:** 10th International Congress on the Future of Breast Cancer, California/Coronado (San Diego), Internal Medicine, Obstetrics/Gynecology, Oncology, Plastic Surgery, Radiology/Imaging, Surgery
  Email: **brian.waggoner@pergrouplp.com**
  Website: **www.cancerlearning.com/index.cfm/fuseaction/conference.showoverview/id/5/conference_id/675**
- **July 21–24, 2011:** 12th International Lung Cancer Congress, California/Carlsbad, Internal Medicine, Oncology, Radiology/Imaging, Respirology, Surgery
  Email: **brian.waggoner@pergrouplp.com**
  Website: **www.cancerlearning.com/index.cfm/fuseaction/conference.showoverview/id/5/conference_id/676**
- **July 28–30, 2011:** Improving Pain Management and End of Life Care for Primary Care, Wisconsin/Wisconsin Dells, Family Medicine.
  Email: **info@mceconferences.com**
  Website: **www.mceconferences.com**
- **November 29–30, 2011:** Breast Cancer Controversies 2011, United Kingdom/London, Obstetrics/Gynecology, Oncology, Surgery
  Email: **breastscreening@kenes.com**
  Website: **www.breastcancermeeting.co.uk**
- **December 6–10, 2011:** 34th Annual San Antonio Breast Cancer Symposium, Texas/San Antonio, Oncology
  Email: **sabcs@uthscsa.edu**
  Website: **www.sabcs.org**

## 2012

- **March 21–24, 2012:** 8th European Breast Cancer Conference, Austria/Vienna, Oncology, Other Specialties
  Email: **ebcc8@ecco-org.eu**
  Website: **www.ecco-org.eu/conferences-and-events/ebcc-8/page.aspx/2163**
- **May 31–June 1, 2012:** New Frontiers in Persistent Pain, France/Paris, Pain Management
  Email: **events@abcam.com**
  Website: **www.abcam.com/index.html?pageconfig=resource&rid=12881**

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