

HOT SPOT

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



Volume 9, Issue 3, August 2007

Editorial

By Edward Chow, MBBS, MSc, FRCPC

Summer has arrived. Toronto Sunnybrook Regional Cancer Centre has been renamed Odette Cancer Centre following the generous contribution of Mr. Edmond Odette and his family. Odette Cancer Centre still falls under Sunnybrook Health Sciences Centre and is fully affiliated

with the University of Toronto. Details are included in **Hot Spot**.

Also in this issue, Dr. P. Hébert discusses error in health care. Dr. M. Chaban highlights the suffering, taboos and interventions. Dr. L. Librach updates us with the new initiatives in advance care planning in Canada. Dr. E. Barnes

reports on the review of RRRP and the advanced practice radiation therapist. Dr. E. Szumacher provides the latest list on continuing medical education. The insert is written by Dr. S. Stern on new options for the treatment of moderate pain. We hope you continue to find **Hot Spot** informative.

Ethics matters

Error in health care

By Philip Hébert, MD, PhD

Next time you or a family member needs a medical procedure or test done, you should recognize that health care is a risky business. When Mrs. Atkinson (a pseudonym) had a CAT scan done and did not hear from her physician for the next year, she wrongly assumed the test was normal. It wasn't, but it failed to be noticed by her attending doctor until the following year. When he did so, the abnormality on the CAT was much more advanced. When Mr. Cochran (also a pseudonym) was admitted to hospital and was offered medications by the nurse, he assumed, wrongly, that they were his – they weren't, they were the medications of the patient next to him. Mr. Cochran was simply in the wrong bed. When Mr. Hunter (yes, another pseudonym) was given a prescription for a new antibiotic, he didn't realize that he was being given a medication to which he was known to be allergic. He wrongly assumed the doctor knew his allergies, but she didn't, she had forgotten to ask.

These less-than-optimal events are common in medicine. Patients get the wrong drugs, the wrong diagnoses are made, tests are delayed, the wrong procedures are carried out, or the outcomes from the procedures are not what were intended. It has been estimated in Canada that 7.5 per cent of all hospitalized patients suffer an "adverse event" during the hospitalization – these are harmful events that could have been avoided. This is probably an underestimate of what can go wrong in the care of patients as these figures are derived from chart reviews. Of course, many events that are not optimal are not recorded in the patient's chart. Other events, such as pain and suffering of patients, are not captured by these figures either.

Just how commonly mistakes are made in medicine is not known. Sometimes, we only find out when a hospital or health care professional obtains media publicity. For example, in Newfoundland it recently has come to

light that pathological diagnoses of women with breast cancer were improperly made in 40% of more than 800 women – this compares with the

continued on page 2...

In this issue of HOT SPOT:

Ethics matters

Error in health care

Edmond and Gloria Odette make landmark investment at Sunnybrook to help fight cancer

Suffering, taboos and interventions

New initiatives in advance care planning in Canada

Research Corner

Review of the Rapid Response Radiotherapy Program (RRRP) at the Odette Cancer Centre (OCC)

Continuing Medical Education

Insert:

New options for the treatment of moderate pain

Edmond and Gloria Odette make landmark investment at Sunnybrook to help fight cancer

Gift is the largest the hospital has received in support of its cancer program and will establish the Edmond Odette Cancer Centre

On Tuesday June 26, 2007, cancer care and research in Ontario received a tremendous boost in the form of a visionary investment from Edmond and Gloria Odette to Sunnybrook Health Sciences Centre's cancer program. To honour the Odettes' philanthropy, the Toronto Sunnybrook Regional Cancer Centre has been renamed the Edmond Odette Cancer Centre. The Odettes' funding is targeted to improving patient care.

Edmond Odette co-founded, with his brother Louis, Eastern Construction, one of the largest construction companies in Canada. From the entire Sunnybrook family and everyone who has benefited from the exceptional care provided here, we thank them.

The Odette Cancer Centre at Sunnybrook Health Sciences Centre provides care to more than 10,000 new patients every year and offers a full range of outpatient and inpatient treatment and supportive care programs, is a Cancer Care Ontario partner and is fully affiliated with the University of Toronto.



Mr. Leo Steven, President and CEO, Sunnybrook; Dr. Linda Rabeneck, Vice-President, Regional Cancer Services, Sunnybrook and Regional Vice President, Cancer Care Ontario; Honourable Kathleen Wynne, Minister of Education and MPP for Don Valley West; Mr. Edmond Odette, philanthropic leader in the community and long-time supporter of Sunnybrook Health Sciences Centre.

It is the sixth largest comprehensive cancer centre in North America, ranked among a select group that engages in intense research and community outreach and provides the full spectrum of patient care.

For more information, call Ms. Natalie Chung-Sayers, Sunnybrook Community & Stakeholder Relations (416) 480-6100 x2253

Error in health care

...continued from page 1

"accepted" error rate of two to four per cent. Could things be as bad elsewhere? Quite frankly, we don't know because we haven't looked frequently enough. What particularly concerned patients and their families was a lack of transparency from hospitals and clinicians when these errors came to light. Some women found out about the problem by reading the newspaper. It is not so much the original error or mistake that bothers patients or their families – it is a lack of honesty and forthrightness about these events that makes the original error less forgivable. Everyone knows that health care professionals can be perfectly good

professionals and make mistakes. Health care is under-funded, patient problems can be complex, and anyone can have a bad day. What the public expects is that clinicians will take the problem of error seriously and do their best to address it openly and to prevent such errors from affecting others in the future.

The next time you or a family member needs a test or a procedure done or needs to be hospitalized, make sure you or they have someone to accompany them. If you aren't certain what is going on, ask. If you don't hear about a test, ask. If you aren't sure about a procedure, ask – you always have a right to a second opinion. But remember this: no matter how risky health

care might be, it is certainly better than the alternative: no health care. Mostly, things in medicine go well. If you have a health issue, do consult a health care professional and do go to hospital if it is recommended that you do so. But keep your wits about you and make sure you bring a friend or family member with you. They can be your eyes and ears when you are unable to be involved in decisions due to your illness. Sunnybrook, as with many other hospitals, has patient safety efforts (ask your clinician about these), but they can only do so much. Patients and families are encouraged to bring to the attention of the hospital concerns about the quality of the care they receive.

Suffering, taboos and interventions

By Michele Chaban, RSW, PhD

Familial statistics presented at both an international and Toronto-based conference say one in four families will experience intimate partner violence (IPV). In 2004, Statistics Canada's General Social Survey reports that seven per cent of Canadians in a current, previous or common law union had experienced IPV in the last five years. It is believed that women can experience 10 or more spousal attacks in their lifecycle, encounter more serious types of violence and are four to five times more likely to die from a violent act than men. These figures raise issues for health care.

Ontario's Domestic Violence Death Review Committee (2005) suggests that IPV is both preventable and predictable. This assumes that early identification would positively reduce IPV. At some point, cases of progressive IPV can find their way into health care systems when the victims request treatment for the symptoms of their assault. When these symptoms present, do we treat the cause or simply the symptom?

The health care system has been conflicted about how to respond to IPV. This conflictedness can reinforce the taboos, sense of shame, neglect and abandonment for the victims. This response may be driven by a lack of training/expertise, an unwillingness to breach an individual's or family's boundaries, that IPV is a matter for legal, not health care systems or it is simply too costly to conduct universal screening.

How does our response to IPV promote health and well-being in families? Driven by values and beliefs that intend to honour privacy and boundaries in families, this sensitivity can be a barrier to care and may discourage intervention in IPV. Given the risk to families and professional caregivers who provide care to this population, it is a situation that is worthy of reflection.

It can be argued by those who have greater expertise in IPV, that IPV does

not require universal screening. Arguments opposing systemic screening are based on the costs (screening time) to the health care system, as well as fear of amplifying the violence in the family. This later argument is similar to that used for not opening Pandora's box: too many woes will show themselves. Yet, I have worked with situations of domestic violence where, as a matter of course, we ask every client about the safety of their home, work/school environment and their relationships.

If we are treating people and families, rather than pathologies, and if there are positive clinical experiences of assessment and intervention resulting from asking the question, why is this not being done routinely? There are historical precedents driving our thinking on IPV that appear to be value and belief driven. As professional caregivers in a multicultural society, we have tended to view family violence as a private matter. It was thought that addressing IPV was too personal and anyone, no matter what their class, culture, religiosity, spirituality, gender or economic status, could find it offensive. It was and is a concern that addressing IPV serves to heighten the threat to women/ children/ family. Fear of repercussion leaves us in a quandary about if, when and how to intervene. Yet, if women and children are abused daily and some abuse leads to death, is this a repercussion we are prepared to bear? IPV mortality reviews often show where we could have intervened to make a difference, but that no one did.

Collecting evidence on IPV leads to legal, moral and relational repercussions for health care professionals and families. Intervention is complicated and requires time to deal with the complexities, unless IPV protocols are integrated into concepts of health, making it a matter of course and safety for all. The literature shows there is a reluctance to accept a patient's claim of domestic violence

without corroboration from an outside source. If someone has pain, do we need corroboration from an outside source? Is IPV not a source of familial pain?

Dealing with these cases can be demanding, time is money and this is the essential argument against universal screening. There can be legitimate time constraints in a busy medical clinic/office. This speaks to the need for inter-professional, if not inter-agency, protocols to reduce/manage this burden of care.

We are far from this response. Since the health care system has not systemically viewed IPV as its responsibility, there is a general lack of education, training and systemic care to attend to it.

Why is this? Health science tends to focus on four goals: assessment, diagnosis, treatment and cure. Optimally, these goals pertain to the management of disease. Optimistically, we hope that the patient will recover and get better. However, not all of the scenarios we encounter fit into this goal-directed paradigm. With IPV, assessment may or may not elucidate the risks. Relationship-building, which encourages a sense of trust, protectionism and caring, can help encourage the successful disclosure of IPV. In the case of IPV, there are no tests or medication that can identify or remedy the situation. It takes intervention at many levels over time by many people to ensure the diminishment of IPV.

Are there other models of health and well-being that might more aptly support intervention with IPV? The social determinants of health offer hope of more suitable intervention strategies. In particular, we may be able to apply IPV indicators, thereby making it a preventable and predictable phenomenon.

The social determinants of health include:

- Biology and genetic endowment
- Education
- Employment and working conditions

- Gender
- Health services (knowledge, access, utilization)
- Income and social status
- Social environments
- Social supports
- Networks
- Physical environments (housing, safety at home/work)
- Personal health and coping skills

Health Canada's Population Health Framework, Health Canada

If the majority of violence is directed towards women and children, would it not be fair to view IPV as a family health issue, for there are men involved in IPV as perpetrators and, I would argue, as victims.

Although my expertise is on dying and death both in the family and in health care systems, my sensitivity and understanding of IPV came from a colleague who works in obstetrics. A consultation was requested on a young woman, mother of one child, expecting her second. Her pregnancy did not put her at risk, but her life did. This young mother presented to the obstetrical unit with a heightened sense of protectionism towards her in utero child. She had high anxiety and was hyper vigilant. Over time and with trust, this woman spoke about her history of severe abuse that had almost taken her life on several occasions. She had since escaped the abuse, was under police protection, had established a nurturing home, had a viable job and was living successfully as a single-parent family.

After many attempts to diffuse the situation clinically, my colleague asked that I see this woman and offer my thoughts. On presentation, most of this woman's distress could have been viewed as normal lifecycle adjustments: she was a single mom, pregnant, with a history of IPV. My colleague sensed something else was driving this mother's distress. When I began seeing this woman, I agreed. Over the course of time, we discovered and discussed

the woman's experience of IPV and the very real deaths she had faced at the hands of her partner whom she was now separated from legally and geographically. Although she was giving birth, she was haunted by her experiences of almost dying.

We could have treated this solely as a case of anxiety or trauma. We could have dealt with her meaning making. Instead, we went deeper, to explore this woman's death value system (Kastenbaum). At her young age, her only experience with death was both unnatural and violent, full of torturous experiences that she could not speak about to others. If not for my colleague's clinical expertise and her commitment to eradicating IPV, this woman would have carried this burden, perhaps forever. Today, this mother has two children and is planning her wedding. She and her children have been living protectively, but with a sense of personal safety for many years. Working from the social determinants of health, we built a life for her so she was no longer a victim. It was her new life and the presence of a new life within her that had her wrestling with her experiences with death.

This is not a case of one. Persons who have lived through war, persecution, genocide, famine and incarceration may also have similar experiences of almost dying and/or almost dying from neglect or abuse. What are we to do with all of this?

It was not too long ago that we walked the halls of some of the most reputable health science centres and found people with unmanaged pain. H/P/EOLC said this was not acceptable and began an intense and successful campaign to have the knowledge, skills and intervention capability to manage pain. We now have a body of literature and an expertise known as pain and symptom management. Our intentions seemed impossible and threatening to some when we began this process. To do this, we had to bring about change in people's values, beliefs and clinical knowledge.

What do IPV and pain and symptom management have in common? Much of how we respond to both these scenarios is based on our personal and systemic values about suffering. Attending to suffering takes on many forms in health care. Whether it is family violence, unnatural, painful and/or untreated experiences with dying and death, or simply pain and symptom management, if we do not attend to these types of suffering, then who will?

Treating suffering can be subtle and complex for it can take a set of clinical skills that rely on intuition, relationship-building and perceptual nuances. Author Anais Nin offers this wisdom: "We don't see things as they are; we see things as we are". How we deal with our own suffering will be how we deal with other's suffering.

As we build our theories of psychosocial-spiritual interventions with families, whether it is in end of life or life itself, let us remember that one of our greatest strengths is that we have a history of being able to make a difference for others. IPV, pain and symptom management and suffering may not be curable entities. However, the situation and the people involved can be healed. Healing people focuses on reclaiming their wholeness. Healing families is a complex strategy that focuses on helping them to positively activate the social determinants of health at individual and familial levels. IPV and death can be twin experiences that have carried a sense of taboo for health care professionals. Yet H/P/EOLC has shown that we can find a way to speak about the taboos, and sensitive intervention can be taught. Not to treat suffering heightens risks to all involved. How to treat suffering remains a body of intervention literature for us to develop across the health care system.

Dr. Michele Chaban is cross-appointed to the Faculties of Social Work, Family and Community Medicine, and The Centre for Bio-ethics at University of Toronto. She is a PhD supervisor at University of Wales and has a private practice.

New initiatives in advance care planning in Canada

By Larry Librach, MD, CCFP, FCFP Director, Temmy Latner Centre for Palliative Care

As health care therapies and technologies progress and people with many complex diseases, including cancer, live longer, advance care planning (ACP) is becoming increasingly important. There is considerable evidence that advance care planning is poorly done, often happening only at the very end of life when crises occur, when life-sustaining treatments have been instituted despite issues of poor prognosis, and when patients are not capable of making decisions about the care they want. It is all about determining and respecting choices for future care and appointing someone to speak for a patient if he/she becomes incompetent to make decisions about care.

ACP involves all health care providers having continuing conversations with patients and families throughout the course of illness, especially as goals of

care change. ACP involves talking about complex and sensitive issues, mostly around end-of-life care, and discussing what options for treatment should be considered. Although attention has been paid to advance directives, documents such as living wills, the majority of advance care planning involves discussions and written records of those discussions in health care records.

The role of the health care professional is to be an active and sensitive partner in helping patients work through their feelings and values about what treatments they would want or refuse, especially if they become unable to express themselves. Dying and death are not comfortable topics of conversation in our society, perhaps especially for health care practitioners who are trained to cure disease and heal injury, but also for patients with life-threatening

conditions who are commonly urged to fight for life, not plan for dying.

In order to support the need for ACP, regional health authorities in the provinces and the federal government are promoting programs to educate patients and families and to educate health care providers about this important area. The Educating Future Physicians for Palliative and End of Life Care Project (EFPPEC) has developed an educational module that will be released soon as one of the components of a national project in this area. The Fraser Health Region in British Columbia and the Calgary Health Authority in Alberta are Canadian leaders in this area and recently sponsored the first Canadian conference on ACP at the beginning of May. Some of the hospitals in Toronto are beginning planning on how to educate health care professionals and their patients on issues of ACP.

Research Corner

Review of the Rapid Response Radiotherapy Program (RRRP) at the Odette Cancer Centre (OCC)

By Toni Barnes, MD, FRCP(C)

This work by Mr. Eric De Sa, a research student in the RRRP, is a review of the RRRP clinical experience from 2003 to 2006. This is an update of previous work published by Dr. Danjoux (Danjoux, Chow, Hayter, et al., 2006), which reported on the first eight years of our RRRP clinic. The purpose of this work was to review the clinical activity of the RRRP over the last three years to determine whether the objectives of the program are continuing to be met. The RRRP general database records demographics, diagnosis and treatment for every patient seen in the clinic. Retrospectively, the patient population and time interval between referral to consultation, consultation to simulation and simulation to treatment were analyzed for the past three years. Results showed that from 2003 to 2006, 1,798 patients were seen in the RRRP. Just over half (51.9%) were male, and the median age was 69 (range 22 to 101 years). Breast (20.0%), lung (34.8%) and prostate (14.1%) primaries accounted for almost

70% of referrals. Sixty-four per cent of patients seen were new to the RRRP. Most patients (72.5%) came from home, the rest were inpatients at Sunnybrook or an outside hospital. The median duration from referral to consultation was five days, and from referral to treatment six days. Most patients were referred for palliative treatment of bone (52.5%) or brain metastases (21.5%). Approximately three-quarters (76.2%) of patients seen in consultation were ultimately treated with palliative radiotherapy, and most were planned and started treatment that same day. Only 416 (23.2%) patients had previous radiation treatment. We concluded that the RRRP is continuing to provide rapid access to palliative RT for cancer patients with symptomatic locally advanced or metastatic disease.

Reference

Danjoux, C., Chow, E., Hayter, C., et al. (2006). An innovative rapid response radiotherapy program to reduce waiting times for palliative radiotherapy. **Support Care Cancer**, 14(1), 38-43.

Advanced practice radiation therapist in palliative radiotherapy

The Ministry of Health has funded a pilot project for an advanced practice radiation therapist (APRT) in palliative radiotherapy. This position will be held by a radiation therapist with expertise in the clinical and technical perspectives of palliative radiation medicine. Optimizing patient care and maximizing patient health outcomes through expanded, direct and comprehensive care, education, research, professional and organizational leadership is the focus of this position. The APRT will triage referrals to the RRRP from a variety of clinics, prescribe radiation therapy, order simulation and approve radiation therapy plans/images for specific patient group(s). The APRT will also serve as technical and clinical consultant to groups outside the RRRP. We are all very excited about this new position, which will allow us to expand the scope of the RRRP throughout Sunnybrook Hospital.

Continuing Medical Education

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 lists the Canadian CME activities in palliative medicine that are of interest to our readers. Please forward details of the CME activities to:

Ewa.Szumacher@sunnybrook.ca

- July 30-August 1, 2007 – **Caring for Mind, Body and Spirit: Psychosocial, Bereavement and Spiritual Needs at the End of Life**, Albuquerque, NM. www.nhpc.org
- August 17-18, 2007 – **Perspective in Oncology Supportive Care**, Washington, DC. www.asoncology.com
- August 28-31, 2007 – **9th Australian Palliative Care Conference: Partners across the Lifespan**, Melbourne, Australia. Contact: ICE Australia, www.iceaustralia.com
- September 6-9, 2007 – **Pain Educators Forum 2007**, Las Vegas, NV. Contact: dw@paineducators.org
- September 8-13, 2007 – **9th Biennial ESTRO Meeting on Physics and Radiation Technology for Clinical Radiotherapy**, Barcelona, Spain. www.estro.be
- September 12-14, 2007 – **ELNEC – Oncology**, Pasadena, CA. www.aacn.nche.edu
- September 19-21, 2007 – **Hospice & Palliative Care Manitoba – Annual Provincial Conference “Caring for the Caregiver”**, Winnipeg, MB. www.manitobahospice.mb.ca
info@manitobahospice.mb.ca
Phone: (204) 889-8525
- September 25-28, 2007 – **4th World Congress: World Institute of Pain – WIP**, Budapest, Hungary. <http://kenes.com> - Contact: Ethan Greenberg
- September 27-29, 2007 – **7th Asia Pacific Hospice Care Conference – “Nurturing Partnership in Hospice Care”**, Manila, Philippines. www.aphc2007.com
- September 30-October 3, 2007 – **International Society for Quality in Health Care – 24th International Conference of ISQua**, Boston, MA. www.isqua.org
- October 24-28, 2007 – **World Hospice & Palliative Care Day – Cancer in Africa: Challenges and Opportunities**, Cape Town, South Africa. www.worldday.org
www.africa.aortic.org
- October 27-November 1, 2007 – **ASTRO 49th Annual Meeting, Los Angeles Convention Center**, Los Angeles, California. American Society for

Therapeutic Radiology and Oncology, 12500 Fair Lakes Circle, Suite 375, Fairfax, VA 22033-3882. Phone: (703) 502-1550 or 800-962-7876 www.astro.org

- October 28-31, 2007 – **Canadian Association of Nurses in Oncology (CANO) – 19th Annual Conference “Using Hearts, Mind and Voices: Oncology Nurses Influencing Cancer Care”**, Vancouver, BC. www.cano.acio.ca
Barb.Wilson@uhn.on.ca
Phone: (604) 874-4322
- November 4-7, 2007 – **2007 Canadian Hospice Palliative Care Conference – “Hospice Palliative Care: At a Crossroads”**, Toronto, ON. www.chpca.net
- November 12-16, 2007 – **Multi-Professional Week in Palliative Care**, London, United Kingdom. www.stchristophers.org.uk
- November 29-December 1, 2007 – **National Hospice & Palliative Care Organization – 8th Clinical Team Conference**, New Orleans, LA. www.nhpc.org

Continuing Medical Education Activities

- University of Western Ontario Certificate in Palliative Care and Death Studies (on-line)
- Service Provision in Hospice/Palliative Care, www.advancedprofessionaleducation.com
- Hospice Palliative Care Multidiscipline Certificate – Humber College, pamela.mckintuck@humber.ca
- RTS Perinatal Bereavement Support Training, www.pbso.ca
- Comprehensive Bereavement Skills Training – COPING Centre – Cambridge, www.griefsupportt.ca
- Companioning Suicide Survivors – COPING Centre – Cambridge, www.griefsupportt.ca
- Humber College Annual Conference on Palliative Care – Toronto, www.palliativecare.humber.on.ca
- Ian Anderson Continuing Education in End of Life Care – Toronto, www.cme.utoronto.ca/endoflife/
- Bereavement Ontario Network Conference (each September), www.bereavementnetwork.ca
- National Conference of Hospice Palliative Care – Canada, www.chpca.net
- Palliative Care Certificate Program, Distance Program – Grant MacEwan College, Edmonton, www.macewan.ca/palliative
- Compassionate care for the Terminally Ill (four non-credit distance program) – Grant MacEwan College, Edmonton, www.macewan.ca/palliative

The newsletter of the Rapid Response Radiotherapy Program of the Odette Cancer Centre is published through the support of:



**Abbott
Laboratories, Ltd**



AstraZeneca



Amgen



Boehringer Ingelheim



GlaxoSmithKline



Kyphon



Novartis



Ortho Biotech



Pharmascience



Purdue Pharma



Sanofi Aventis



Solvay



Valeant Canada



VitalAir

Vol. 9, Issue 3, August 2007

Founders: Dr. L. Andersson, Dr. C. Danjoux

Editor: Dr. E. Chow

Associate Editor: Dr. C. Danjoux

Consultant: Dr. S. Wong

Advisers: Dr. L. Barbera, Dr. E. Barnes, Dr. R. Goldman, Dr. A. Husain, Dr. L. Librach, Dr. C. Newman, Ms. E. Sinclair, Dr. E. Szumacher, Dr. M. Tsao

**Editorial and Financial Managers:
Mrs. M. Frost and Ms. S. Lue**

Odette Cancer Centre,
Sunnybrook Health Sciences Centre,
2075 Bayview Avenue,
Toronto, Ontario M4N 3M5
Tel: 416-480-4998, Fax: 416-480-6002
E-mail: edward.chow@sunnybrook.ca
Website: <http://www.sunnybrook.ca/programs/occ/treatmentprevention/rapidresponse>
Produced by Pappin Communications,
Pembroke, Ontario www.pappin.com