Winter 2000

CANCER Care

INSIDE

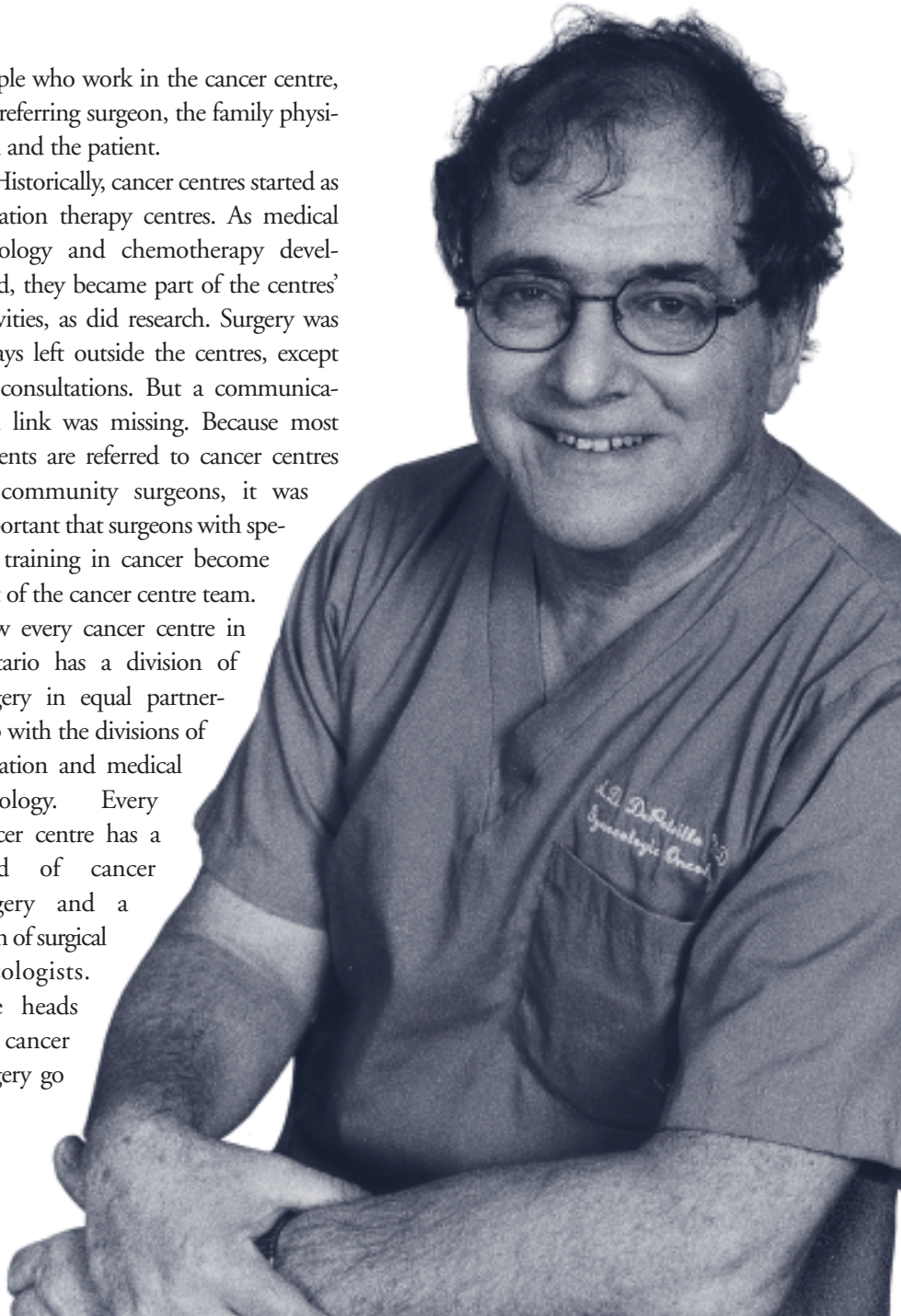
Cancer *surgery:* Getting ORGANIZED

Each year in Ontario, approximately 50,000 people are diagnosed with cancer, and half will undergo surgery. To ensure that patients receive the surgical services, information and support they need as close to home as possible, Cancer Care Ontario recently formed the Surgical Oncology Network (SON). The network links general, specialty and cancer surgeons (called surgical oncologists) across the province. Cancer Care *magazine asked network coordinator Dr. Denny DePetrillo to explain how the SON works and how it will benefit people who need cancer surgery.*

Q: Can you tell us about the network and why it was created?

A: The Surgical Oncology Network is designed to provide information that will help surgeons make decisions about whether or not to operate, or, if a complex operation is needed, to refer the patient to a centre with facilities to handle this type of surgery. SON is a communication network among the people who work in the cancer centre, the referring surgeon, the family physician and the patient.

Historically, cancer centres started as radiation therapy centres. As medical oncology and chemotherapy developed, they became part of the centres' activities, as did research. Surgery was always left outside the centres, except for consultations. But a communication link was missing. Because most patients are referred to cancer centres by community surgeons, it was important that surgeons with special training in cancer become part of the cancer centre team. Now every cancer centre in Ontario has a division of surgery in equal partnership with the divisions of radiation and medical oncology. Every cancer centre has a head of cancer surgery and a team of surgical oncologists. The heads of cancer surgery go



out and visit the community surgeons, attend hospital rounds, videotape conferences for surgeons, and present information at workshops. Communication is the whole purpose of the network—to generate and provide information on cancer surgery that will result in good decision making and excellent patient care.

Q: How will the network benefit people who have cancer and need surgery?

A: I think it will benefit patients in several ways. First, we will provide patients with information about their cancer surgery. The network also gives surgeons information that will help them determine whether or not the patient needs an operation. If so, what type of operation does the patient need? Can it be done in the local hospital, or are services needed that are only available in a larger, regional centre? Is the experience of the surgeon enough to do this particular operation?

Answers to these questions are important to help a surgeon make a decision. The technical competence of surgeons is not the issue; we are blessed because surgeons in Ontario are very well trained. But cancer is only part of a surgeon's practice, and we would like to help them by providing the information to make these important treatment decisions. We hope that eventually the Surgical Oncology Network will mean improved outcomes in cancer surgery, such as higher rates of success in removal of cancer, and increased survival.

Q: How will we know if these efforts improve the outcomes of cancer surgery for patients?

A: We are in the process of monitoring outcomes, which hasn't been done before. We're in an era of cancer care delivery where we have to be accountable for what we do.

We've looked at outcomes for pancreatic cancer surgery and for colorectal *(bowel)* surgery, and we're starting to look at outcomes for ovarian cancer surgery. Over time, we'll continue to go down the list and look at the outcomes of the different types of cancer surgery. We're working closely in partnership with the surgeons in the hospitals to share information, to help them audit outcomes and to encourage their participation in establishing treatment guidelines for different types of cancer surgery.

Pancreatic surgery is complex surgery. Our research showed that the death rate from pancreatic surgery was double in hospitals that performed few of these operations compared to hospitals where many more were done. We struck a task force to look at this issue. The task force included patients, surgeons, researchers, administrators and provincial government representatives. We came up with recommended requirements for surgical training and for hospital support—both from a human resource point-of-view in terms of anesthesia, intensive care and nursing, and for physical resources such as diagnostic and interventional radiology. These minimum criteria, which we believe are necessary to offer complex pancreatic surgery, were sent to every chief executive officer and heads of

"Communication is the whole purpose of the network—to generate and provide information on cancer surgery that will result in good decision making and excellent patient care."

Dr. Denny DePetrillo is coordinator of the Surgical Oncology Network.

surgery in Ontario hospitals. The response has been very positive, and we know that some of the smaller hospitals that don't have these levels of support stopped doing pancreatic surgery. We will continue to monitor pancreatic surgery to ensure that patients receive the best care.

When we looked at colorectal cancer surgery, which is less complex, we found that there is essentially no difference in outcomes whether it's done in a community hospital or in an academic hospital, as long as there's a good decision-making process in place. Our aim is to have patients receive their cancer surgery close to home whenever possible. For most colorectal cancer surgery, this is possible.

Q: What other kinds of research is the network involved in?

A: The other important research project under way is to look at waiting times for cancer surgery *(for details see the Fall 1999 issue of* Cancer Care *magazine or* Cancer Care On-Line *at www.cancercare.on.ca)*. In February, we started looking at waiting times for patients who see surgeons at the eight regional cancer centres and their host hospitals. This follows a pilot study done last year at Princess Margaret Hospital, in which they measured the time between a patient's first visit to a surgeon and the patient's surgery. The data showed that waiting times at the hospital varied from six to 12 weeks depending on the type of disease and the investigations that were required. We don't know whether waiting four, six, eight or nine weeks actually changes the chance of success. That kind of research hasn't been done. But we have a lot of information on anxiety among patients awaiting cancer surgery, and we plan to ensure that patients receive their cancer surgery as soon as possible.

We hope that by doing this study in the regional cancer centres, we can set a maximum recommended length of time that patients anywhere in Ontario should have to wait for cancer surgery. We will then ask surgeons in the community hospitals to undertake their own studies to see how their waits compare to the recommended standard.

Q: What other methods will the network use to improve information, communication, and therefore, surgical care?

A: Newsletters, the SON Web site, information packages for surgeons about the most appropriate management of patients with cancer, information packages for family physicians and patients, and workshops—these are some of our activities and plans. We also will work with organizations that provide information to patients, and with the professional associations representing surgeons. We have a Provincial Advisory Committee for Surgical Oncology that includes the heads of cancer surgery from the cancer centres, two community surgeons, two patients and representatives from different surgical organizations. There is a cancer surgeon on each of the eight Cancer Care Ontario Regional councils to ensure that information is transferred among the Surgical Oncology Network, the cancer centres and other providers of cancer care.

Because of geography, cultural and other factors, the needs of patients and surgeons vary widely across the province. We believe that by opening up the lines of communication, offering more cancer surgery information, and selecting those cases that should be done in larger centres while the majority of surgery continues to be done locally, we can improve cancer surgery for patients in Ontario.

For further information about the Surgical Oncology Network, visit the Web site at www.son.on.ca

The NEXT generation of *cancer doctors*

Studentship helped Dr. Robert Bristow to make decisions about his career.

"I gained an appreciation for the enormity of the task of treating one child with cancer, the magnitude of resources required and the invaluable nature of every member of the oncology *(cancer)* team." That's how second-year University of Ottawa medical student Anne Dobson, 24, describes her 1999 summer job. She spent 11 weeks helping to care for kids with cancer at the Children's Hospital of Eastern Ontario. The most important lessons she learned: "That a cancer diagnosis impacts the entire family; that there *is* life with cancer; and that for children with this disease, it's very important to have fun."

Although it is early in her medical training, pediatric oncology is on Anne Dobson's short list of career choices. She was one of 25 Ontario medical students to receive last year's Ivan H. Smith Memorial Studentship. The students worked a total of 147 weeks at cancer centres and hospitals. The hope is that they will join the next generation of oncologists, or cancer doctors.

Since the mid-1960s, the annual awards have provided selected medical students with work experience in adult and pediatric cancer care settings. The studentship was named in honour of the late Dr. Ivan H. Smith, a renowned radiation oncologist who served as the first director of the cancer clinic in London, Ontario.

For Robert Bristow, his 1992 summer studentship at Toronto's Princess Margaret Hospital wasn't about deciding on a career in oncology. The question was whether to become a full-time cancer researcher or to blend a research career with a clinical practice treating patients.

The studentship…is one of many strategies to encourage young people to pursue careers in cancer care.

"The Ivan Smith studentship solidified my choice to do both," says Dr. Bristow, a radiation oncologist and clinician/scientist who joined the staff of Princess Margaret Hospital in 1996. "The studentship allows medical students to see what oncology is all about, and to find out if they can function well as oncologists. It provides an excellent opportunity to hone the craft of clinical medicine and to learn about decision management."

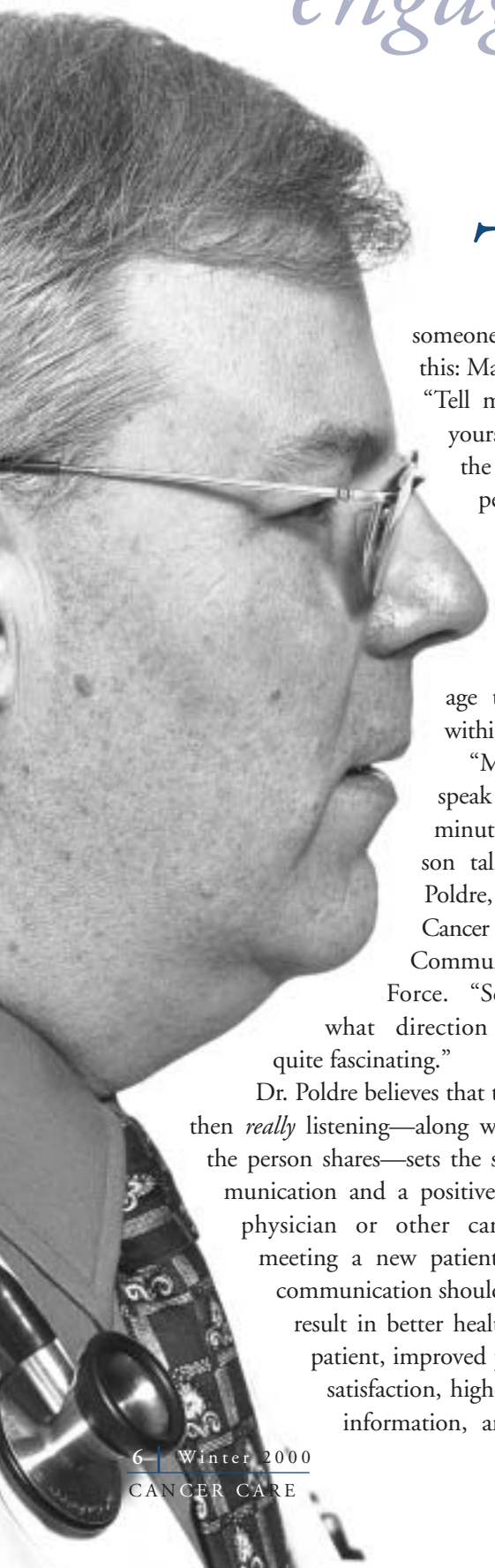
Ontario is short of cancer doctors, nurses, radiation therapists and medical physicists. The studentship, sponsored jointly by Cancer Care Ontario and the Canadian Cancer Society, Ontario Division, is one of many strategies to encourage young people to pursue careers in cancer care.

empathize

engage

The ART

and other ways to improve communication with patients



The next time you sit down to talk with someone you've just met, try this: Make a request such as, "Tell me something about yourself." Then listen to the answer. While the person is talking, keep eye contact, give encouraging nods, but do not interrupt (research shows that on average the asker interrupts within 18 seconds!).

"Most people won't speak beyond two to three minutes. Just let the person talk," says Dr. Peeter Poldre, a member of the Cancer Care Ontario (CCO) Communication Skills Task Force. "See what happens, what direction they go in. It's quite fascinating."

Dr. Poldre believes that the act of asking and then *really* listening—along with the information the person shares—sets the stage for open communication and a positive relationship. For a physician or other cancer care provider meeting a new patient, establishing good communication should be a priority. It can result in better health outcomes for the patient, improved patient and clinician satisfaction, higher quality diagnostic information, and a better chance that the patient will follow the treatment plan and make lifestyle changes.

While setting the stage for open communication might take a few extra minutes, that time investment can pay big dividends. By listening to the patient—perhaps learning something non-medical about them—and then taking the time to discuss their concerns and questions, issues can be resolved early, and patient and family stress is reduced.

This simple listening technique is one of many practical tips in three workshops created by the Bayer Institute for Health Care Communication. Two CCO staff members from each of the eight regional cancer centres have been trained to present the workshops. Since 1996, more than 1,300 CCO physicians, clinical staff, medical residents, students, community doctors and other health care providers have participated. A typical clinician will conduct more than 100,000 interviews with patients during his or her career.

"We believe that CCO is the first large-scale North American cancer care system to offer communication skills training to its employees," says Bayer's Lori Ann Horrigan.

"We're in an age when a person with a serious illness goes to a health care professional and expects not only to benefit from their expertise, but also to be comfortable asking that person questions," adds Raylene Godel, a survivor of breast cancer, and a member of the task force and CCO's board of directors. "As baby boomers age,

of *listening*... *enlist* *educate*

there will be even more demand for good communication between patients and caregivers."

The Clinician/Patient Communication workshop is about "the human-to-human relationship that we should be developing between patients and their families, and health care professionals," says Dr. Poldre. It focuses on the four E's: engaging the patient, empathizing with them, educating the patient and family, and enlisting participation in their cancer care. The Difficult Clinician/Patient Relationships workshop "provides practical information about how to work through uncomfortable situations." Choices and Changes explores how to make lasting changes in behaviour and lifestyle.

Running the three workshops is the "perk of my job," according to Margaret Lerhe of the Ottawa Regional Cancer Centre (ORCC). "I enjoy learning about employees' communication concerns and working together to solve them." It's the workshops' simple lessons she finds most rewarding: taking the time to say good morning to people, making eye contact, smiling at a patient or staff member, remembering to introduce herself and learning not to interrupt people when they're talking. "People's lives are so chaotic and stressed that these common courtesies can be forgotten. For example, we encourage receptionists to look up from the computer screens and charts when they greet patients—to connect with them across the desk."

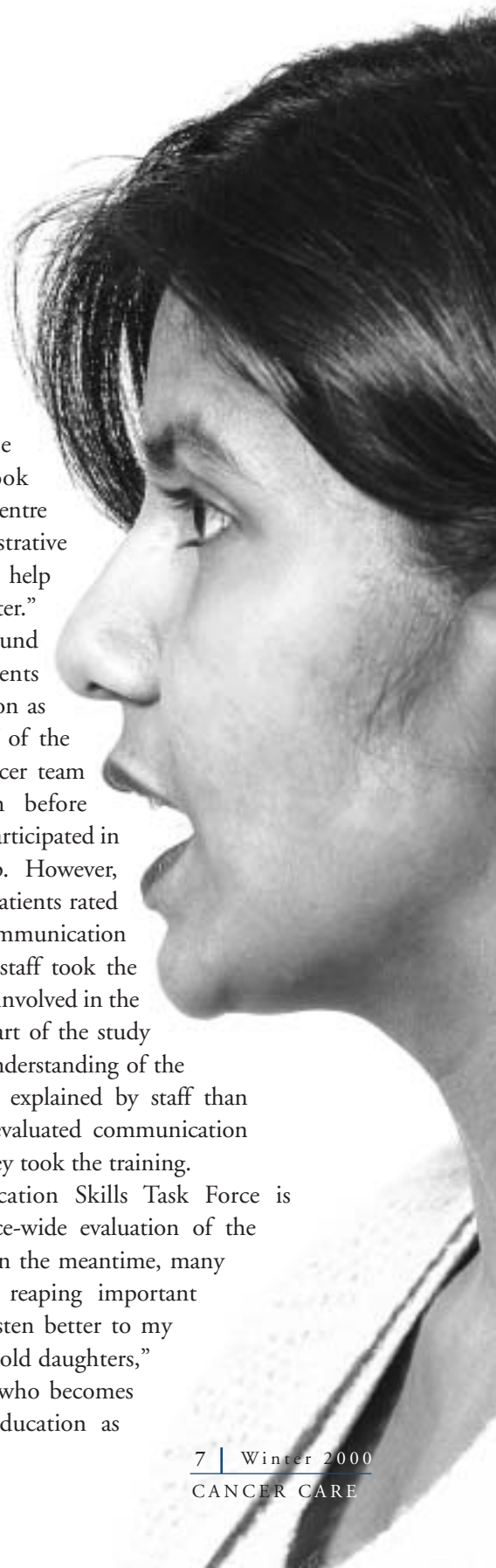
Another important strategy is to "try to put yourself in the patient's shoes, understand their perspective. In the workshops we talk about really *seeing* the patient, *hearing* the patient and *accepting* them."

"I've always felt empathy toward patients' situations," says ORCC nurse Sharon Weller. "But this workshop has taught me to listen more effectively, acknowledge the patient's concern, look them in the eye and be able to respond."

Yvonne Rohlehr agrees. "It makes a difference when you really listen to what patients are saying," says the Toronto-Sunnybrook Regional Cancer Centre (T-SRCC) administrative assistant. "You can help them better and faster."

A recent study found that 80% of patients rated communication as excellent with staff of the head and neck cancer team at T-SRCC—both before and after the staff participated in the first workshop. However, the other 20% of patients rated the quality of communication much higher after staff took the workshop. Patients involved in the "after workshop" part of the study reported a better understanding of the cancer information explained by staff than did patients who evaluated communication with staff before they took the training.

The Communication Skills Task Force is planning a province-wide evaluation of the training program. In the meantime, many staff say they are reaping important benefits. "I even listen better to my seven- and 10-year-old daughters," smiles Dr. Poldre, who becomes CCO's head of Education as of April 1.



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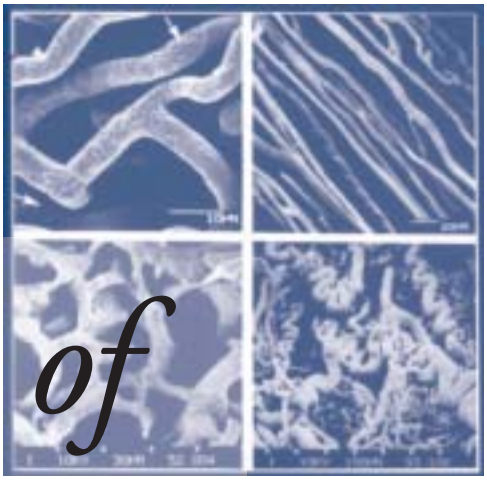


Young cancer researcher awarded

As strange as it may seem, cancer cells need a good supply of oxygen in order to be destroyed effectively. If they are deprived of oxygen (hypoxic), they become very resistant to both chemotherapy and radiation therapy. This reality has challenged one of Canada's most promising young cancer researchers, Dr. Bradly Wouters, to work on a whole new approach to treating tumours.

On a molecular level, cancer cells go through an evolution as they grow. At first they reproduce very quickly and chaotically. To do this, they need a blood supply that delivers oxygen and other nutrients.

As the tumour expands through unrestrained cell division, the network of blood vessels is crowded and becomes disorganized. The vessels are often underdeveloped, and are forced to twist and turn to reach the cells they are trying to nourish. Consequently, a portion of the tumour receives less oxygen, and the growth of the tumour slows.

Chemotherapy is carried to cancer cells through the blood system. If blood isn't getting to all of the cells or if the cells are not growing, the chemotherapy drugs cannot be effective. Likewise, radiation therapy is compromised because it requires oxygen at the time of delivery to effectively kill the cancer cells.

Dr. Wouters' groundbreaking research recently earned him the Polanyi Prize for Medicine.

Dr. Wouters, a career scientist at the Ottawa Regional Cancer Centre (ORCC) and an assistant professor at the University of Ottawa, is studying a new drug that appears to be highly effective at killing hypoxic cancer cells. It is called tirapazamine (TPZ) and was developed at Stanford University, where Dr. Wouters received his postdoctoral training. TPZ becomes toxic to cancer cells only when they are deprived of oxygen. When used in combination with a conventional chemotherapy drug, cisplatin, TPZ damages the genes in the cancer cell and then kills it.

TPZ is so promising that it is now being tested in clinical trials. However, scientists still don't understand how it works. Dr. Wouters and his colleagues at

Dr. Bradly Wouters in his Ottawa laboratory.

ORCC are looking at how hypoxia affects cells at the molecular level, and how hypoxic cancer cells activate TPZ. They are also examining how cells repair themselves following DNA damage. DNA repair is an important factor in the response of tumours to treatment. It also plays a key role in the development of tumours because errors in DNA repair lead to mutations and the creation of cancer cells.

"We are trying to exploit the fact that these cells are hypoxic," says Dr. Wouters. "If we can identify how they change at a molecular level, and how they are affected by drugs like TPZ, we can develop new and better treatments."

Dr. Wouters' groundbreaking research recently earned him the Polanyi Prize for Medicine. The Polanyi Prize—named for Nobel Prize-winning chemist Dr. John Polanyi—is awarded not for a single discovery, but for a larger body of significant and innovative work. Each year as many as five prizes are presented to outstanding researchers in the early stages of their careers. These awards are sponsored by the Ontario government, and have a value of $15,000 each.

Dr. Bradly Wouters (left) won the Polanyi Prize, named after Canadian Nobel Prize-winning chemist Dr. John Polanyi (right).

"In the academic world, you earn appreciation and respect from your colleagues by publishing," says Dr. Wouters. "The Polanyi Prize, on the other hand, brings us public recognition and prestige. This is very appreciated."

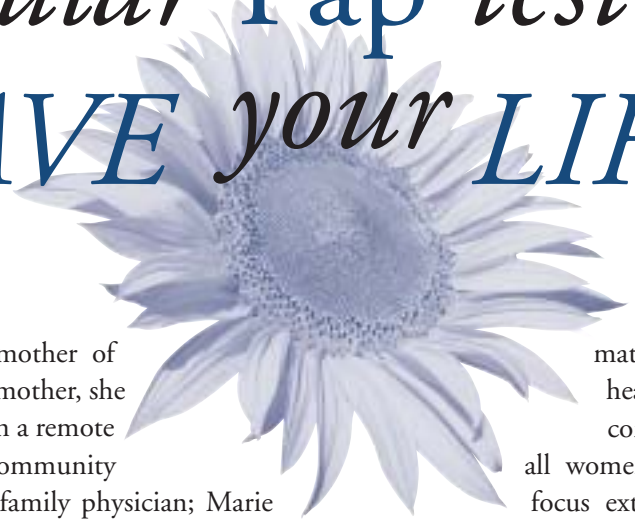
At the age of 30, Dr. Wouters already has an outstanding academic and scientific track record. A native of Saskatoon, he completed a bachelor of engineering physics at the University of Saskatchewan. He did postgraduate studies at the University of British Columbia, completing his PhD in physics at the British Columbia Cancer Research Centre. Next he accepted a junior fellowship from the National Cancer Institute of Canada and went to Stanford University to work as a postdoctoral fellow in radiation oncology. When that was over, he began to weigh his options.

"I always felt I wanted to come back to Canada. This is a wonderful country," says Dr. Wouters. "But I also wanted to go somewhere where I could be successful and benefit from the support of a group of colleagues."

He found that group at the Ottawa Regional Cancer Centre. "The environment here is very appealing," he says. "We all share one floor of the building—10 scientists with no boundaries between our labs.

"Their work also complements my own. These are people I can collaborate with."

A regular Pap test could SAVE your LIFE



Marie is 62. The mother of three and a grandmother, she has lived her life in a remote town of 2,000 people. The community does not have a permanent family physician; Marie hasn't been to a doctor in years. A visiting physician comes to town and Marie decides to see her. A Pap test is done and Marie gets the news that she has cancer of the cervix.

While Marie is not a real person, stories like this have been heard time and again by the staff of Ontario's public health units. With the launch this June of the Ontario Cervical Screening Program by Cancer Care Ontario, the province's 37 public health units look forward to increased public awareness about the benefits of regular Pap testing. A public awareness campaign at the provincial and local levels will help public health units to carry out one of their mandates: to ensure that all women are aware of the importance of regular Pap tests, and see their physicians for screening.

"Cervical cancer is not a cancer you find mentioned in the media very often. This needs to become a topic women discuss with one another," says Dr. Susan Kaczmarek, medical officer of health for the Porcupine Health Unit, and a member of the Ontario Cervical Screening Collaborative Group. "The campaign will create much more interest in what we're doing, not only among women but also among our other partners—primary care physicians, obstetricians, gynecologists—to all work together in reaching more women."

Program materials for the Ontario Cervical Screening Program will be identified by a sunflower logo. Resource materials will be created for public health units to tailor for use in their communities. The plan is to reach all women, but public health units will focus extra efforts toward hard-to-reach women. Some of the barriers to screening include differences in language and culture, age, education and socioeconomic status, long distances to travel, and limited access to medical care. Future plans for the Ontario Cervical Screening Program include a cervical screening registry, and a recall program for women who are overdue for their Pap tests.

A woman should have a Pap test every year for the first three years after she becomes sexually active. If these first three tests are normal, a Pap test should be repeated at least every two years to the age of 70. The test involves the examination of a small sample of cells removed from a woman's cervix. By having regular Pap tests, cell changes can be found early and treated, and cancer usually can be prevented.

Increasing use of the Pap test in Ontario has been credited with a 46% reduction in the incidence of and death rate from cervical cancer since 1971. However, the disease remains a significant health problem; almost 600 women are diagnosed, and approximately 190 women die annually from cervical cancer.

"What we have here is a cancer that is almost completely preventable," explains Dr. Kaczmarek. By working together, she believes that public health units, the Ontario Cervical Screening Program, physicians, nurses, community groups and women can help to prevent cervical cancer and save many lives.

Dr. Jack Laidlaw

Helping the public with cancer information

A major job of Cancer Care Ontario (CCO) is to give the public useful information about cancer prevention, early detection, treatment and supportive care. This information should help people make decisions that will improve their health. Cancer education programs must be easy to access, understandable and acceptable to the range of people who live in Ontario.

In a study for CCO's Education Advisory Committee, Dr. Elizabeth Kaegi found that the ways now used to provide cancer information to the public, such as same-for-all pamphlets written in English or French, are not effective in reaching and influencing many people across the province. She identified three under-served groups: people with low literacy, people from low socioeconomic groups, and people from non-English and non-French cultures. Together they represent more than half of Ontario's population.

The study showed that cancer education programs will be effective only if they respond to an important problem experienced by people, and offer a practical and credible solution. People in the under-served groups must help develop and deliver the programs, and the programs must show respect for those they are trying to reach. Cancer education programs should be offered in familiar settings such as homes, grocery stores, beauty salons, churches and community centres. They should use familiar formats, such as television (e.g. soap operas and other programs), radio, the Internet and videotapes.

"Cancer education programs should be offered in familiar settings such as homes, grocery stores, beauty salons, churches and community centres."

Sensitivity is key when preparing cancer education messages for people with low literacy. Many people read at two to three grades lower than the highest level they achieved at school. Approximately one-third of adult Canadians cannot read the materials they need for daily living. One-to-one conversations followed by illustrated, personalized print materials written in plain language is another approach.

Time and cost are barriers to effective cancer education, especially for people with limited money. Offering cancer education programs in the workplace, helping with travel costs and providing day care could reduce these barriers. For groups from non-English, non-French cultures, the study suggested that community leaders become involved because they have a major influence on their people. Cancer education programs should be bilingual—the language of the audience plus English or French—and should address the diversity within each group, including education level and the degree to which people have adopted the cultural practices of other groups.

Dr. Kaegi also noted that it is easier to change behaviours that are not required often than it is to get a person to change lifestyles. For example, a woman is more likely to go for breast screening every two years than to quit smoking. If a change in behaviour involves services from cancer care providers, then education programs for both the public and the providers should be available.

Plans are now under way for a pilot study in the Central West region of Ontario (Hamilton area) to test ways to effectively deliver cancer education programs to under-served populations. The study will focus on screening for bowel cancer.

Dr. Jack Laidlaw is head of Education for Cancer Care Ontario.

On the Cover

Jackie Hatherly-Martin and daughter, Emily

Cervical cancer has changed my life, but doesn't rule it. It has taught me not to take my health for granted, and that it's okay to be a little selfish. In 1975, my mother died of cancer at age 37. Just two years ago, my dad died at 62 from a brain tumour. Cancer has a way of making you think about what's important.

Last June, I gave up my job as a financial controller. Working 60 hours a week didn't leave much time for my daughter, Emily, and left even less time for me. Now I set my own work hours doing part-time freelance bookkeeping. I have time to play with Emily; we paint and do crafts. I take a painting class and I'm setting up a woodworking shop in our basement.

In 1994, six months after Emily was born, I had a series of Pap tests with abnormal results. Before that, my Pap results had always been fine. At age 32, I was diagnosed with cervical cancer. Although we wanted more children, and there were treatment options that might have made that possible, I decided to have a hysterectomy. It turned out to be the right decision. The tumour had spread beyond the cervix and there was a small amount of cancer in one of the lymph nodes. My surgery was followed by 28 radiation treatments.

Today, I'm healthy and I continue follow-up at the London Regional Cancer Centre. Cervical cancer usually can be avoided—or successfully treated if it's caught early. We're lucky to have the Pap test, but it's every woman's responsibility to get it.

"The tumour had spread beyond the cervix and there was a small amount of cancer in one of the lymph nodes."

Cancer Care Ontario

Cancer Care Ontario (CCO) is the province's leader in the integration and coordination of cancer control services, and the Ministry of Health and Long-Term Care's principal adviser on cancer issues. CCO's work includes cancer prevention, screening, treatment, supportive care, research and the development of treatment guidelines. Eight Cancer Care Ontario Regional (CCOR) councils plan and coordinate regional cancer services. CCO manages Ontario's eight regional cancer centres, the Ontario Breast Screening Program, the Ontario Cancer Genetics Network and the Ontario Cancer Registry.

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