

# HOT SPOT

## From the editor's desk

By C. Danjoux, MD, DMRT, FRCPC

We welcome the Temmy Latner Group as a regular contributor to our newsletter. In this issue, they address the topic of end-of-life care distance education. This is an innovative approach to help physicians care for palliative patients. Anyone interested in registering for the course is invited to contact the office of Continuing Education.

The recent media coverage of Terri Schiavo's end-of-life care raised controversial ethical and legal issues. Karen Faith offers a thoughtful perspective on how an institution dealt with this controversy and provides us with a valuable lesson.

Health care is a stressful occupation. Obviously physicians are not the only ones to be feeling the problem. Many studies report the experience and impact of stress on health care workers. Mary Vachon reviews the stress experienced by health care workers and questions whether we are making progress.

Many of our patients use non-conventional methods to control their symptoms.

Hypnosis is an intriguing and poorly studied method of controlling pain in cancer patients. Lori Holden and Charles Hayter present their results of a survey to assess cancer patients' awareness and interest in hypnosis for pain and distressing procedures. Their results provide valuable information, which may result in a prospective study of the role of hypnosis in symptom control.

Our educational insert is on a minimally invasive approach to treat metastatic spine lesions. Both vertebroplasty and kyphoplasty are offered at the Sunnybrook & Women's College Health Sciences Centre. Dr. Michael Ford's insert on this topic provides a useful summary of our current approach for the treatment of selected metastatic spinal lesions.

We hope you are having an enjoyable summer and find this issue informative and enjoyable.

## A survey to assess cancer patients' awareness and interest in hypnosis for pain and distressing procedures – A synopsis

By Lori Holden, BSc, MRT(T) and Charles Hayter, MA, MD, FRCPC

Pain is a common problem for patients with cancer. Standard medical management consists of analgesics, or anti-cancer treatment using palliative radiotherapy or chemotherapy. Patients whose pain is not relieved by conventional treatment often seek out complementary or alternative treatment, with hypnosis being an option.

Hypnosis is a technique involving a state of deep relaxation and focused attention. It has been used for headache, burn injury, arthritis, dental problems, and backache. A meta-analysis of 18 studies in both experimental and clinical pain revealed a moderate to large hypno-analgesic effect, which supports the efficacy of hypnotic techniques for pain management.

*continued on page 4...*

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*The Newsletter of the  
Rapid Response Radiotherapy  
Program of Toronto Sunnybrook  
Regional Cancer Centre*

**Vol. 7, Issue 3, August 2005**

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**Produced by  
Pappin Communications,  
Pembroke, Ontario  
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**In this issue:** A survey to assess cancer patients' awareness and interest in hypnosis for pain and distressing procedures – A synopsis; Are we making any progress? Reflections on stressors in the Ontario oncology system over the past 30 years; Organizational ethics in the eye of the storm: Woodside Hospice and Terri Schiavo; Temmy Latner Centre Update on Palliative Care;

**Insert - A more minimally invasive approach to the treatment of metastatic spine lesions**

# Are we making any progress? Reflections on stressors in the Ontario oncology system over the past 30 years

By Mary L.S. Vachon, RN, PhD

Grunfeld, Zitzelsberger, Coristine, Whelan, Aspelund and Evans (2005) recently published an article on job stress and job satisfaction of cancer care workers. I was interested to learn that amongst the Cancer Care Ontario staff surveyed (physicians, allied health professionals, secretarial and administrative staff):

- Patient care or patient contact was the major source of satisfaction, even if their job involved little patient contact
- Oncology was felt to be a special environment, often because of the longstanding relationships with patients
- Having good relationships with patients, families and colleagues were the three top sources of satisfaction
- Being perceived to do the job well was fourth highest for all groups
- Having variety in one's job was amongst the top five for all groups.

These sources of satisfaction sounded familiar as I reflected back more than 20

years ago to interviews I did with close to 600 caregivers from around the world. Professional caregivers of all disciplines were asked about the stress they experienced in the care of the critically ill, dying and bereaved; what factors impacted on their perception of stress; how their stress was manifested; and how they continued to cope in the midst of all the illness, suffering and death to which they were exposed. Over and over again, caregivers would say, "I love my work, I'm good at it and I have some control over what I do and how I do it (Vachon, 1978).

When the data for those in oncology (N=110) were analyzed separately (Vachon, 1991), the most common coping mechanisms were: a sense of competence, control and pleasure in one's work; developing multiple roles; a personal philosophy of illness, suffering and death; a sense of team philosophy, support and team building; and formalized decision-making (Vachon, 1991). These findings seemed similar to the recent Grunfeld et al. findings.

As I recently began to write my sixty-fourth article or chapter on the subject of some variant on staff stress (Berger et al., in press), I wondered how similar the stressors that CCO caregivers are experiencing in this new century are to those in the past. The table below compares the stressors from my earlier work in the area of occupational stress to the recent interesting findings of Grunfeld et al. Plus ça change, le plus ce la même chose.

## References

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Vachon, M.L., Lyall, W.A., & Freeman, S.J. (1978). Measurement and management of stress in health professionals working with advanced cancer patients. *Death Educ.*, *1*(4), 365-375.

Mary Vachon, RN, PhD, is a psychotherapist in private practice and may be reached at [maryvachon@sympatico.ca](mailto:maryvachon@sympatico.ca).

PMH Nurses – 1971	Oncologists and Oncology Residents in 1970s	International Sample of Oncology staff – 1980s (N=110)	CCO Staff 2000
<ul style="list-style-type: none"> <li>• Difficulty dealing with the emotional needs of patients and families</li> <li>• Lack of resource personnel</li> <li>• Problems with staff communication</li> <li>• Watching patients suffer and die</li> <li>• Feelings of personal inadequacy</li> <li>• Pressure to discharge dying patients because of being an active treatment hospital (Vachon, Lyall, &amp; Freeman, 1978).</li> </ul>	<ul style="list-style-type: none"> <li>• Role strain dealing with research and clinical issues when patients are dying</li> <li>• Residents trying to decide for themselves which model of care to follow</li> <li>• Rotating interns and residents fearing prescribing narcotics because of risk of addiction</li> <li>• Tremendous workload imposed by the prevalence of cancer, the increased life expectancy and chronic nature of the disease</li> <li>• Patients demanding more active involvement; to arrange treatment around their schedules and to stop treatment when they feel that it is doing no good</li> <li>• Ever-increasing demands to be sensitive to and deal with the psychosocial needs of patients, families, and staff (op cit)</li> </ul>	<p><b>Stressors</b></p> <ul style="list-style-type: none"> <li>• Patient/family difficulties with coping or personality problems</li> <li>• Patient/family difficulties in communication</li> <li>• Role overload</li> <li>• Team communication problems</li> <li>• Identification with patient/family</li> <li>• Role ambiguity</li> <li>• Role conflict</li> <li>• Inadequate resources</li> <li>• Communication problems with others in the system</li> <li>• Unrealistic expectations of organization</li> <li>• Lack of control (Vachon, 1987)</li> </ul> <p><b>Manifestations</b></p> <ul style="list-style-type: none"> <li>• Depression, grief and guilt</li> <li>• Anger, irritability and frustration</li> <li>• Job-home interaction</li> <li>• Feelings of helplessness, insecurity and inadequacy</li> <li>• Avoidance of patients/families (Vachon, 1991)</li> </ul>	<p><b>Stressors</b></p> <ul style="list-style-type: none"> <li>• Need established standards for appointment times, waiting times for treatment and tests, and workload</li> <li>• Inadequate staffing</li> <li>• Heavy workloads</li> <li>• Job-home interaction</li> <li>• Being involved with the emotional distress of patients</li> <li>• Increased incidence</li> <li>• Increase in the complexity of cases</li> <li>• Available treatment options (e.g., new agents to palliate advanced stage cancer, new agents to treat previously untreatable cancers)</li> <li>• Better-informed patients</li> <li>• Health service restructuring and reduced spending has led to downsizing of hospital acute and chronic care services</li> <li>• Fewer health care professionals</li> <li>• Changing roles and responsibilities for health care workers</li> <li>• The increasing demand for oncology care has not been consistently matched with a commensurate increase in human and material resources, or improvements in systems of care delivery (Grunfeld et al., 2005)</li> </ul> <p><b>Manifestations</b></p> <p>High rates of burn-out</p> <ul style="list-style-type: none"> <li>• physician exhaustion (53.3%)</li> <li>• 48.8% of physicians reported low feelings of personal accomplishment</li> <li>• 22.1% of physicians depersonalization (Grunfeld et al., 2000)</li> </ul>

# Organizational ethics in the eye of the storm: Woodside Hospice and Terri Schiavo

By Karen Faith, MEd, MSc, RSW

My daughter Jess and I happened to be in Tampa, Florida, last March as right-wing and liberal politicians, TV celebrities and bioethicists touted their opinions on CNN about the tragic circumstances of Terri Schiavo. Terri Schiavo, age 41, had been in a persistent vegetative state for 15 years. Over time, her husband Michael Schiavo came to the conclusion that based on her previously expressed capable wishes, his wife would not want to be sustained on life support. What ensued was an ethical and legal debate that captured the hearts and minds of the western world. Aside from the political and ethical debates this case raised, what struck me most were media images of Woodside Hospice. Its front doors were swarmed by groups of people. Some were defending Schiavo's right to refuse unwanted treatment. Others offered to provide "their sister" with food and water. Each group seemed to represent the various sides in the moral/political debate surrounding Schiavo's life, rights and destiny. I asked myself whether a health care institution like Woodside Hospice is able to maintain its values

about care in such an atmosphere of political wrangling and heightened media attention.

From an organizational perspective, Woodside Hospice faced several formidable ethical challenges. The first obvious challenge was maintaining patient privacy. Friends, family and former care providers of Terri Schiavo spoke freely with the press. While treatment and care provided to Schiavo was publicly discussed by people from outside the hospice, Woodside could not respond or comment because of its obligations to patient privacy. Patient privacy was further complicated when a nurse, employed by a private agency to work temporarily at Woodside, disclosed to the media that she had evidence of Michael Schiavo's attempts to kill his wife. Woodside remained remarkably and discretely silent.

Terri Schiavo's case was exceptional in most settings, but particularly for Woodside Hospice. The institution is dedicated to quality end-of-life care, honouring patient's wishes, demonstrating leadership to the health community and providing nutrition to the extent that the patient desires nourishment and is able to ingest food. For almost seven years while this debate about Schiavo raged,

Woodside accommodated the patient and family, and made allowances about care choices like continued nutrition hydration. Such life-sustaining measures over a long period were not entirely consistent with institutional values about palliative care.

In addition, rights, needs and freedom of other patients and their families were seriously impacted by the political and public response to Schiavo's care. Patient privacy and security became even further complicated and ethically problematic as the media's gaze rested on Woodside's doorstep and routine screening and searches were instituted at its entrance. Woodside faced the ever-increasing dilemma of meeting the needs of Terri Schiavo and her family, while also ensuring that the needs and rights of other patients and their families were equally considered.

Health care institutions could learn from the extraordinary experience of Woodside Hospice, how it maintained its organizational values within its provision of care to Terri Schiavo, her fellow patients, their families and supporters.

*Karen Faith is a clinical ethicist at Sunnybrook and Women's College Health Sciences Centre.*

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## *Temmy Latner Centre Update on Palliative Care*

### End-of-life care distance education: An innovative approach to helping physicians to care for palliative patients

Anita Singh, MD, CCFP  
and Deborah Adams, MA, MHS

Over the last 10 years, palliative care has gained both public and professional acknowledgement as a critical yet missing component in physician education. In response to this, in 1993, the Ontario government established some annually funded programs to promote palliative care in Ontario. One of these initiatives (initiative two) was targeted at family doctors.

The Ontario Ministry of Health recognized that family doctors played a key role in caring for dying patients and their families, but that they lacked training. The Temmy Latner Centre for Palliative Care was given the responsibility of

developing programs for physicians in the York, Simcoe, and Toronto regions.

Over the past 10 years, this course has undergone a number of transformations. In October 2004, we launched an on-line distance education program as well as an advanced communications course. The programs that have been developed are innovative and have been recognised as making a significant contribution to the education of family physicians. The use of integrated E-learning, videoconferences and standardized patients have allowed the program to meet the learning needs of a much wider group of physicians across the region and across the spectrum of skills and experience. The courses, although targeted towards family doctors, have

been found useful by interested FRCPC physicians who also wish to increase their knowledge and skills in the field of palliative care.

The introductory, on-line course consists of two videoconferences and five on-line modules. The more advanced one-day retreat for teaching communication skills uses standardized patients. Both courses will be offered again in September of 2005. Registration information is available by calling the Office of Continuing Education at (416) 978-2719, by e-mailing [ce.med@utoronto.ca](mailto:ce.med@utoronto.ca) or on-line at <http://icarus.med.utoronto.ca/eolCare/index.htm>. Anyone interested in enhancing their skills through either the introductory or advanced course is encouraged to call.



## TSRCC investigates advanced practice radiation therapy roles!

By Sheila Robson, MRT(T), ACT, BSc,  
Ruth Barker, MRT(T), BSc, MEd  
and Lori Holden, BSc, MRT(T)

The Ministry of Health and Long Term Care is investigating the efficacy of advanced practice roles for radiation therapists in Ontario. A request for proposal (RFP) to develop five individual radiation therapy advanced practice roles was sent to all the cancer centres in Ontario. A number of RFP's were submitted for evaluation by a multidisciplinary selection committee, which was comprised of a variety of stakeholders. TSRCC submitted three proposals and was successful in obtaining funding to develop all three. The roles for investigation are: Advanced Practice (AP) Skin Cancer Therapist; AP Therapist for Patient Assessment and Symptom Management (Review); and AP Palliative Care Therapist. Other successful proposals were from Hamilton, Kingston and the Princess Margaret Hospital. An exciting offshoot is that three palliative proposals were accepted for joint development. This bodes well for palliative radiation programs across Ontario.

Having an AP Therapist in Palliative Care within our own Rapid Response Program has many potential benefits. We envision that the AP RTT will be a key resource and function as an autonomous practitioner to provide streamlined clinical palliative consultations, improve the process of accessing palliative radiation therapy, and improve patient care and patient outcomes of palliative patients. We look forward to the challenge of this project and hope to provide updates about the project as the year progresses.

Additional information available at: <http://www.ontarioradiationtherapy.ca/members.asp> for those interested in finding out more about the AP4RT website.

## Hypnosis

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The use of hypnosis for cancer pain in adults, however, has not been well-studied. The increasing interest in non-pharmacologic strategies for relief of cancer pain and the lack of prospective studies using hypnosis has inspired our interest in exploring this area. However, before embarking on a clinical efficacy study, we decided to examine the degree to which patients are interested in exploring hypnosis. Therefore, we conducted a survey to assess cancer patients' awareness and interest in hypnosis for control of pain and distressing procedures.

Using focus group feedback from health care professionals and patients, we developed and piloted a 16-item questionnaire. Patients attending the Toronto Sunnybrook Regional Cancer Centre and Princess Margaret Cancer Centre were approached to participate in the survey. Those who consented were asked to complete the survey.

We accrued 100 patients from July 2004 to January 2005. Fifty-six per cent were male and the mean

age was 65 years. The key results from this survey showed that 57% were interested in trying hypnosis to help with their pain/distress. Sixty-three per cent were interested in learning more about hypnosis, and almost half were interested in learning self-hypnosis. Seventy-one per cent were interested in exploring non-pharmaceutical ways to deal with pain and almost half were interested in participating in studies to evaluate the effectiveness of hypnosis.

The results of this research project show that patients attending the radiotherapy palliative clinics are interested in exploring other types of interventions, including hypnosis, to help with their cancer pain/distress. Although the majority of patients were unaware that hypnosis has been used to relieve cancer pain, there is interest by patients to learn more about and to participate in hypnosis studies. This information will help direct us in future research in this area. We plan to look at efficacy studies of hypnosis for pain control. If you would like more information on this study, please contact me at [lori.holden@sw.ca](mailto:lori.holden@sw.ca).

The newsletter of the Rapid Response Radiotherapy Program of Toronto Sunnybrook Regional Cancer Centre is published through the support of:



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