

# HOT SPOT

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



Volume 20, Issue 1, February 2018

## Editorial

By Dr. Edward Chow

Welcome to the February 2018 issue.  
Happy new year.

In this issue, Dr. Blair Henry  
discusses our future dependent and  
vulnerable selves.

Ms. Leslie Gibson and Ms. Tamara  
Homeward outline Smoking Cessation  
as a Standard of Care: It is All of Our  
Responsibility.

F tu0W. Raskin and S. Cheng describe  
the critical care of cancer patients: a  
changing paradigm. Dr. P Paladino and  
Ms. Toby Rodin provide the continuing  
medical education updates.

We hope you enjoy the newsletter.

## Our future dependent and vulnerable selves

By Blair Henry, D. Bioethics

Think it won't happen to you? Think again. In a study published in *JAMA* in 2014 the authors presented research findings that suggested that 68% of all hospitalized adults over the age of 65 faced at least one major medical decision in the first two days of their admission. Of these, 47.4% required at least some surrogate involvement including 23% who needed all decisions made by a substitute decision-maker (SDM). When you dig down into the results, 57.2% involved life-sustaining care decisions, 48.6% involved decisions related to procedures and operations, and 46.9% involved discharge planning.<sup>1</sup> In critical care, where a substantially higher percentage of patients are unable to participate in the decision-making process due to the severity of illness, one could expect involvement of the SDM to be even higher.<sup>2</sup>

Given the legal and ethical allowances for substitute decisions to enable future-oriented patient autonomy, much rests on the knowledge and preparedness of

the SDM to engage in the emotionally difficult task at hand—while keeping the best interests of the patient in mind. Given this, it is important to ensure that every person will have an SDM, regardless of their relational and social networks. In accommodation of this need, SDMs can be appointed legally by the state, supported by legal filings, and by default to the highest ranking 'family' member available. At the extreme ends the court can appoint guardianship for an incapable person; or, when no other means exists, the Office of the Public Guardian and Trustee can be called upon to support medical decisions. In other cases, a capable patient can appoint anyone over the age of 16 to act as their SDM or if an involved individual steps forward they can apply to the Consent and Capacity Board to be appointed to this role. In addition to these legal avenues, the laws support what is considered the 'natural' role of the family to be involved in such matters.<sup>3</sup>

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## Our future dependent and vulnerable selves

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Experience to date suggests that many SDMs are not well prepared to engage in treatment decisions on behalf of an incapable patient. This trend seemingly continues despite the fact that, over the past several decades, there has been considerable promotion, and a growing awareness of the importance of encouraging everyone to have conversations about their wishes with their SDM, and supporting the creation of advance directives. This article will outline and discuss the current status of the empirical data on the progress (or lack of) these efforts to enhance patient autonomy.

### What do we know of SDM accuracy?

An important benchmark for our understanding of SDM accuracy comes out of a systematic review that was conducted in 2006, which reviewed 16 studies that presented a total 151 hypothetical scenarios to 2,595 SDM-patient pairs and collectively analyzed 19,526 patient-SDM responses.<sup>4</sup>

Overall accuracy of SDM based on the meta-analysis was 68% (95% credible interval, 63-72). Variance was noted based on the types of health states used in the scenario. Accuracy was highest for scenarios involving the patient's current health (79%) and lowest for those involving stroke and dementia (both at 58%).<sup>4</sup> Subsequent studies have also shown similar conclusions.<sup>5,6</sup>

### Can physicians do a better job than the SDM?

Analysis of the systematic review identified four studies that attempted to assess physician versus SDM accuracy and all four stated that the SDM is better.<sup>4</sup>

### Can designating an SDM do better than one appointed by the hierarchy?

The ability for advance directives to allow a patient to appoint their SDM instead of the role being assumed by the family hierarchy was intended to enhance

the patient's chance of selecting an SDM who would be willing to act on their behalf and to make decisions in keeping with the patient's best interests. A review of the systematic review showed no significant effect on accuracy based on SDM selection: Patient-designated SDMs were 69% accurate compared to 68% by the individuals assigned by the hierarchy.<sup>4</sup>

### Can having prior discussion of the patient's treatment preferences and values improve accuracy?

The ideal of promoting advance care planning was to encourage patients to have conversations with their SDM about what types of treatment they would or would not want and about their inherent values that might guide decisions in the future. Two studies reported on this: one stated that with discussions the accuracy was 71% and that without discussions the accuracy improved to 74%. The second study showed even poorer correlation: 58% accuracy with discussion and 64% without.<sup>4</sup>

Previous studies have tried to look for correlations between various characteristics such as SDM's relationship to the patient, frequency of contact, sociodemographic characteristics of both parties involved (e.g., gender, age, and education), and prior communication of treatment preferences to determine if any of these covariates were any more predictive of SDM accuracy, without much success.<sup>4,6,7</sup>

However, one study posited that inaccuracy in predicting patients' preferences for life-sustaining interventions in hypothetical health states may, in part, be due to discordance in patients' and the SDM of what quality of life would be like in those states.<sup>7</sup> Older adults who rated quality of life as unbearable, should they be suffering from severe dementia, were 2.7 times more likely to opt for comfort care only rather than life-prolonging care when compared to older adults who rated quality of life in severe dementia more positively.<sup>8</sup> This, coupled with a known tendency for surrogates to underestimate a relative's quality of life, was thought to be a potential marker for the cause of SDM

inaccuracy.<sup>9</sup>

In the research by Bravo et al., the discrepancy in quality-of-life ratings between an older adult and his or her self-selected SDM could explain, at least in part, family members' well-documented difficulty in predicting a relative's desire for treatment in the three hypothetical scenarios (mild to moderate stroke, incurable brain cancer, and severe dementia) investigated. Adjusting for potential confounders had little effect on the results observed—confirming prior research, underscoring the limitations of relying on older adult and surrogate characteristics to predict surrogate predictive accuracy.<sup>7</sup> In fact, the Bravo et al. study showed that discordant views on quality of life in hypothetical health states do influence surrogates' ability to accurately predict an older adult's desire to undergo specific treatments. This finding could guide healthcare professionals in designing more effective interventions, aimed at improving substitute decision makers' ability to predict and honour the wishes of individuals who have lost the capacity to make decisions on their own.<sup>7</sup>

### Conclusions

Patient-designated and next-of-kin SDMs incorrectly predict patients' end-of-life treatment preferences in one-third of cases. The two most commonly endorsed methods for improving surrogate accuracy: patient designation of an SDM and prior discussion of treatment preferences with the SDM, are not effective in improving accuracy. Encouraging conversations between the patient and SDM that focus on helping the SDM understand their views on quality of life in hypothetical health states might improve outcomes. However, further research on this observation is warranted.

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*References available upon request*

# Smoking cessation as a standard of care: It is all of our responsibility

Leslie Gibson, Occupational Therapist, OT Reg. (Ont.), and Tamara Homeward, RN, BSCN, MED, Nurse Clinical Educator, members of Odette Cancer Centre Interprofessional Smoking Cessation Team

Tobacco use is a worldwide epidemic and has a significant health impact on the tobacco user and individuals exposed to second-hand smoke. Tobacco is the leading cause of premature and preventable disease and death worldwide and is implicated in countless disorders and diseases.<sup>1</sup> According to a 2017 report, 15% of the Canadian population report smoking tobacco<sup>2</sup>; although this is a marginal decrease in comparison to previous years, we need to continue with the momentum to decrease prevalence rates.

Smoking is responsible for 30% of all cancer deaths and has a direct link to more than 85% of lung cancer cases.<sup>3</sup> Smoking impacts almost every organ in the human body such as the heart, pancreas and circulatory system, to name a few. It is associated with the development of cancers of the mouth, throat, larynx, esophagus, bladder and cervix.<sup>4</sup> Greater than 7,000 chemicals are found in tobacco that are known to have a negative impact on health. However, quitting smoking is the leading preventable cause of disease and death. Sixty-three percent of current smokers in Canada do want to quit.<sup>5</sup> As a healthcare practitioner, what is your role in reducing smoking to quit for your patients?

In 2011, a Joint Position Statement entitled: “The Role of Health Professionals in Tobacco Cessation” was released by the Canadian Associations of Counselling and Psychotherapy, Dental Hygienists, Medicine, Nursing, Occupational Therapy and Physiotherapy.<sup>6</sup> The statement advocates that every Canadian healthcare professional has a responsibility to address tobacco-use cessation with their patients and clients. Because most Canadians see a healthcare professional at least once a year, we are well positioned to offer “teachable moments” to our patients and counsel them to quit smoking. In fact, best practice dictates that all clinicians should provide smoking cessation interventions at every encounter.<sup>7</sup> The more frequently a smoker is offered strategic advice on smoking cessation from a variety of healthcare providers, the greater the chances of quitting increase.<sup>8</sup> The 2008 WHO Report on the Global Tobacco Epidemic states that after immunization, smoking cessation counselling is one of the most cost-effective interventions a clinician can perform.<sup>9</sup>

In your role, you can have a positive impact by incorporating the 3As of intervention, ASK, ADVISE and ACT, into your routine practice and providing all of your patients with a brief, simple and standardized screening for tobacco use.<sup>10</sup>

**ASK** patients about their tobacco use in the last six months

**ADVISE** patients about the health benefits of quitting

“Quitting or reducing smoking is one of the best things you can do to help your cancer treatment work better and reduce side effects... Being smoke-free will also reduce the chance of your cancer coming back or getting another kind of cancer.”

**ACT** by offering support to quit. Refer your patient to Smokers Helpline “opt-out” program

“I understand that quitting or reducing smoking can be hard, but it’s easier if you have help. I’m going to refer you to the Smokers Helpline.”

Not unlike other modifiable risk factors, the Ottawa Model for Smoking Cessation stresses the importance of smoking to be identified and treated systematically, as part of standard practice in all healthcare settings. By directly referring patients who smoke to the Smokers Helpline, the patient can connect with a smoking cessation specialist, which can lead to a quit attempt.

Cancer Care Ontario (CCO) is now collecting data from each of the Regional Cancer Centres in Ontario. The goal is that every new patient at the Cancer Centre be screened for smoking status. The provincial goal is 70%. If the patient identifies as a smoker, Cancer Care Ontario advocates that they be offered cessation support through a referral to Smokers Helpline, as an example. The acceptance of this referral by the patient is also being tracked by CCO with the provincial goal being 20%. These data are extracted from the organization’s electronic documentation system. It is, therefore, imperative that the smoking cessation assessment and brief intervention be recorded into the patient’s chart.

Research has shown that even a brief intervention lasting less than three

minutes can have a positive impact on abstinence.<sup>11</sup> In the coming months, a greater emphasis will be placed on addressing smoking cessation with our patients. Implementation of a new tobacco control strategy has been outlined by Cancer Care Ontario. Take the opportunity to discuss smoking with your patients. As healthcare providers, it is all of our responsibility. The first step in reducing smoking prevalence rates is to ASK.

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# Critical care of cancer patients: A changing paradigm

By Dr. William Raskin and Dr. Susanna Cheng, Sunnybrook Odette Cancer Centre

When patients with cancer become critically ill, the patient and healthcare team often have to make quick decisions around the goals and value of escalating care to life-supporting measures. This can be extremely difficult, especially when the most responsible team and patient do not have a pre-existing therapeutic relationship. More so, the different perspectives and expertise of critical care specialists and oncologists can appear at odds and be difficult to negotiate. There are opportunities to improve our collaboration and patient care in anticipation of critical illness in the at-risk oncology population.

## When cancer patients become critically ill

Historically, the outcomes of cancer patients admitted to ICU have been so grim that many have investigated if escalating care is altogether futile. This implication largely derives from 1980s and early 1990s retrospective data from bone marrow transplant patients; multiple studies have quoted dismal hospital survival rates following intubation ranging from 0-11%.<sup>1</sup> Among patients with solid tumours and hematologic malignancies alike, retrospective analyses have shown that even after discharge from hospital, prognosis continues to be poor in the long term.<sup>2,3</sup> However, these studies have shown a wide range of outcomes, suggesting that a proportion of these patients can still do well, and no single patient factor can effectively predict a futile admission to ICU. In other words, we can predict poor outcomes for the population, but we cannot accurately identify individuals who will not benefit from critical care.

## A changing landscape

Advances in cancer treatment and critical care have led to improving outcomes of critically ill cancer patients over time.<sup>4,5</sup> In contrast to historical research, more recent retrospective studies have shown that patients with solid tumours have comparable outcomes to the general population after ICU admission.<sup>6</sup> Even among bone marrow transplant patients, a population that seems to benefit the least from critical care, data from Ontario has shown that a proportion of patients admitted to ICU have durable

long-term survival.<sup>7</sup> The progress in both fields has forced a reconsideration of prognosis in acutely ill cancer patients.

### Predicting outcomes

Just as it has proven difficult to predict a group of patients for whom critical care is futile, it has been a challenge to predict which patients derive benefit; unfortunately, this is often an assessment on-call physicians are pressured to make. In one review of oncology patients for whom an ICU admission was considered, almost half were denied admission. What was troubling was that of the patients deemed too well to benefit, 28% were later admitted to ICU, and of the patients deemed too sick to benefit, 26% were still alive 30 days later.<sup>8</sup> With a paucity of evidence-based measures to guide us, we simply are not good at predicting outcomes at the bedside.

### A trial of ICU care

What has been well-validated is that the severity of acute illness is more predictive of long-term outcomes than a cancer patient's past medical history. Multiple composite measures of organ failure, such as SOFA and SAPS II have correlated well to a cancer patient's short- and long-term mortality after admission to ICU.<sup>9</sup> Even more useful is the fact that the trend in organ failure after short days in ICU is strongly prognostic, and this can be applied to patient care. When a cancer patient falls acutely ill, one can propose a time-limited trial of ICU care, an idea well-established in critical care literature. This idea is well-established in critical care literature. This allows the healthcare team time to provide optimal care, acknowledging the lack of clarity in terms of predicting outcomes up front, with the goal of avoiding prolonged and futile care if progress is not made.<sup>10</sup> It also spares

on-call providers the difficulty in trying to establish goals of care under duress and without a pre-existing relationship with the patient.

A suggested framework<sup>11</sup>:

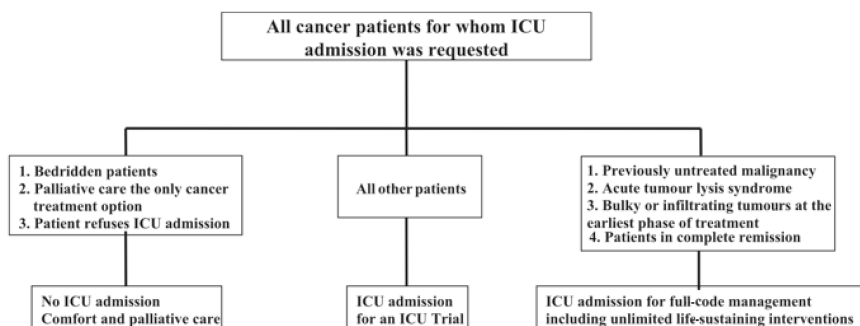
Time-limited trials of critical care, however, are often easier said than done. In reality, patients often have a mixed picture in terms of organ failure when being managed in ICU. For example, a patient can have improvement in renal dysfunction while simultaneously requiring increased ventilator support. For these patients, the trial of ICU care is difficult to interpret. Furthermore, communicating the nuances of multi-organ failure to families and substitute decision makers in a value-laden and emotionally charged setting is always difficult.

The optimal duration of an ICU trial is not clear-cut. In fact, studies examining the optimal duration of time-limited versus unlimited intensive care of cancer patients revealed that different lengths of this trial are appropriate for different patients, including factors such as tumour type and severity of acute illness at the outset, suggesting anything from three to 15 days may be necessary to establish an accurate prognosis.<sup>12</sup> It is reasonable to schedule a family meeting around five days into an ICU stay, but with the caveat that some flexibility may be necessary, and progress may need to be revisited at a later date.

### Initiatives at Sunnybrook

At Sunnybrook, we have patient information and provider educational materials available to help facilitate these discussions and overcome these barriers. We also have an 'advance care planning' discussion note so that if a patient becomes critically ill, their last documented goals of care can be readily

### A suggested framework.



available to an on-call physician. In order to address the needs of patients who are inpatients, there is also an initiative called PROACT, which identifies at-risk patients who are admitted and have a critical care specialist discuss their goals of care. Preliminary data from the PROACT study has shown increased documentation of these plans, as well as patient satisfaction. Only a minority of consults were delivered, with time-pressure the predominant reason cited for lack of consult delivery. However, the majority of patients found the conversation helpful and had never discussed goals of care before, indicating a very encouraging outcome in improving patient care.

<b>PROACT Pilot Results – January to August 2017</b>	
Consults triggered	155
Consults delivered	56 (36%)
<b>Goals of Care Result:</b>	
DNR/DNI documented	25 (45%)
Begun conversation and documented values but no change in GOC	21 (38%)
No documentation	13 (23%)
<b>Patient Satisfaction:</b>	
Questionnaire (0-5)	4.7/5
Conversation helpful	48/51 (94%)
Previous conversation	42/51 (82%)

### Planning ahead:

Managing oncology patients optimally begins before they fall critically ill. Yet, one of the biggest challenges for the oncologist is providing disease-modifying treatment while simultaneously engaging patients in advance care planning. When a disease is irreversible and progressive, and treatment is given with palliative intent, one must delicately help patients “plan for the worst, but hope for the best.” Despite how this often makes people squeamish, there is a growing emphasis on its value, as exemplified by the inclusion of palliative care involvement and discussion of goals of care in ASCO guidelines and markers of quality care.<sup>13</sup> There is also evidence that Canadian cancer patients’ documentation of goals of care is sparse,<sup>14</sup> and this has been explained by time pressures, apprehension around patient attitudes and the impact of discussing morbid subject matter.<sup>15</sup> This is not surprising, as patient surveys have shown a wide heterogeneity in attitudes and willingness to engage in such conversations; yet, many wish to have this conversation in the outpatient setting initiated by their oncology or primary care providers.<sup>16</sup> Though lots of attention should be paid to managing the acutely ill patient, it is equally imperative to initiate these difficult discussions in the outpatient setting, with adequate time for patients to digest the subject matter and discuss their values with loved ones.

### REFERENCES

References available upon request

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# Continuing Medical Education

By Toby Rodin, Odette Cancer Centre, and Patrick Paladino, PhD, eLearning Manager, Oncology Education.com, [elearning@oncologyeducation.com](mailto:elearning@oncologyeducation.com)

Continuing Medical Education (CME) can update healthcare 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 activities in palliative medicine that are of interest to our readers. Please forward details of the CME activities to: [toby.rodin@sunnybrook.ca](mailto:toby.rodin@sunnybrook.ca)

- **April 6, 2018.** Best of GU & GI Cancer Summit Canada. Toronto, Ontario. <http://www.oncologyeducation.com/events/upcoming-events/best-of-gu-gi-cancers-summit-2018/>
- **April 14–18, 2018.** American Association for Cancer Research (AACR), Driving Innovative Cancer Science to Patient Care, Annual Meeting, McCormick Place, Chicago, Illinois, <http://www.aacr.org/>
- **April 18–19, 2018.** Oncology Opinion Series in Melanoma with Dr. Caroline Robert. <https://www.oncologyeducation.com/events/upcoming-events/oncology-opinions-series-melanoma/>
- **April 25, 2018.** CAMO Evening Symposium: Integration of Oncology Biosimilars in Clinical Practice. <https://www.oncologyeducation.com/events/upcoming-events/camo-evening-symposium-2018/>
- **June 1–5, 2018.** ASCO Annual Meeting – American Society of Clinical Oncology, Chicago, IL. <https://www.asco.org/2018-asco-annual-meeting>
- **June 28–30 2018.** MASCC/ISOO Supportive Care Makes Excellent Cancer Care Possible, Vienna. <http://www.masccmeeting.org/2018#.WmlmPdo06ro>
- **July 12–13, 2018.** American Society of Hematology (ASH) Summit on Emerging Immunotherapies for Hematologic Diseases, Washington, DC. <http://www.hematology.org/>
- **September 7–8, 2018.** American Society of Hematology (ASH) Meeting on Hematologic Malignancies, Chicago, IL. <http://www.hematology.org/Malignancies/>
- **Sept. 12–15, 2018.** 2018 CARO-COMP-CAMRT Joint Scientific Meeting, Montreal Quebec. <http://www.caro-acro.ca/annual-scientific-meeting/2018-caro-comp-camrt-joint-scientific-meeting/>
- **October 2–5, 2018.** 22nd International Congress on Palliative Care, Palais des Congrès, Montréal, Canada. <http://www.palliativecare.ca/>
- **October 21–24, 2018.** ASTRO Annual Meeting – American Society for Radiation Oncology, San Antonio, Texas. <https://www.astro.org/annualmeeting/>
- **October 3–5, 2018.** American Association for Cancer Education (AACE); International Cancer Education Conference (ICEC), American Association for Cancer Education AACE, Atlanta Georgia <https://www.aaceonline.com/>
- **November 25–30, 2018.** Radiological Society of North America, RSNA, Annual Meeting, McCormick Place, Chicago, Illinois. <https://www.rsna.org>
- **Dec 4–8, 2018.** 41st Annual San Antonio Breast Cancer Symposium (SABCS) San Antonio, Texas, <https://www.emedevents.com/c/medical-conferences-2018/41st-annual-san-antonio-breast-cancer-symposium-sabcs>

## CME Programs

**What I-O Really Means for Your NSCLC Patients.** In this video, International guest speaker, Prof. Solange Peters, shares the stage with Dr. Sunil Verma to discuss the latest trends on I-O in NSCLC. Patient advocacy group, Lung Cancer Canada, also

provides invaluable patient perspectives.

<http://www.oncologyeducation.com/events/oncologyeducation-events-video-archives/clcco-2017-what-i-o-really-means-for-your-nsclc-patients/>

This program meets the accreditation criteria as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada and has been accredited by the Office of Continuing Professional Development, Faculty of Medicine, McGill University for up to 1 Section 1 credits. Through an agreement between the Royal College of Physicians and Surgeons of Canada and the American Medical Association, physicians may convert Royal College MOC credits to AMA PRA Category 1 Credits™. Information on the process to convert Royal College MOC credit to AMA credit can be found at [www.ama-assn.org/go/internationalcme](http://www.ama-assn.org/go/internationalcme). This program is accredited until March 2017.

**Biosimilars in Clinical Practice – Video Archive.** This 4-part video series provides a comprehensive overview of biosimilars, clinical considerations with trastuzumab and bevacizumab biosimilars, and features a panel discussion with Canadian experts. Click below to view our video archive. <http://www.oncologyeducation.com/events/oncologyeducation-events-video-archives/biosimilars-in-clinical-practice-filmed-discussion/>

**Oncology Opinion Series in Breast Cancer featuring Dr. Dennis Slamon – Video Archive.** In this 6-part video series, Dr. Slamon discusses topics on the molecular diversity of human breast cancers including translational research with cancer cell line panels, an overview of CDK4/6 inhibitors, clinical translation of palbociclib and other CDK 4/6 inhibitors, and lastly, a case discussion. Click below to view our video archive.

<http://www.oncologyeducation.com/events/oncologyeducation-events-video-archives/oncology-opinions-series-breast-cancer-featuring-dr-dennis-slamon/>