Doctor already implementing cancer strategy to save lives

Written by Bernice Trick
Citizen staff
Friday, 17 April 2009

A Prince George doctor carries the fate of future cancer patients in northern B.C. on his shoulders.
Dr. Ronald Chapman, executive director of the Northern Cancer Control Strategy, is responsible for implementing a $151-million project designed to save lives though methods of prevention, screening, diagnosis and treatment.
The cancer control strategy, from prevention through to palliative care, is a huge undertaking that needs to be in place by the time the B.C. Cancer Agency's Centre for the North is completed in 2012, said Chapman.
The cancer centre, where treatment of chemotherapy, and for the first time, radiation therapy, will be delivered during day operations, is only one part of the overall strategy, Chapman said.
"It will be an ambulatory program in which patients come and go for treatment, but any testing or x-rays needed will be done in PGRH where six cancer in-patient beds will be in service."

The Northern Cancer Centre, slated for completion in 2012, is shown in this illustration. (Submitted graphic)

The cancer strategy business plan, approved last June, will basically be implemented by 2012 with costs totaling $99 million for capital for the cancer clinic, $24 million for startup, $25 million projected annually for operating and $3.1 million annually for oncologists, operating the Canadian Cancer Society lodge, and ongoing training for general practitioners in oncology.
The cancer control strategy really got underway in 2005-06 when consultation meetings across the North resulted in a report by Charles Jago and Jeff Burghardt, respectively the current and former Northern Health board chair, showing northern British Columbians wanted a cancer strategy and a cancer centre, Chapman said.
Just prior, in 2005, the B.C. Cancer Agency and Northern Health had begun to concentrate on some areas where they knew they could make a difference like encouraging tobacco reduction and implementing chemotherapy treatment in northern communities, with general practitioners trained to deliver it.
"In 2004 we had nobody, but today we have eight community cancer clinics and 16 family doctors trained in oncology who oversee professional nurses administering chemotherapy," said Chapman.
"We did a systemic therapy review of all the chemotherapy centres with the B.C. Cancer Agency, Northern Health and some external reviewers. We had a look at what was good and what was not so good. It was a good exercise to give everybody an opportunity to see how well the North was functioning compared to B.C. Cancer Agency standards."
Some clinics were doing really well, and some were not. The Quesnel clinic was not

doing well and it was closed in 2005 because it did not meet the standards, but it reopened in 2007 "and today it offers wonderful service," said Chapman, who believes the review exercise of northern cancer clinics showed what requirements were needed and helped to spur a radiation treatment centre in the North.
A trip by officials to Thunder Bay, Ont., which compares with the northern B.C. population and size, also showed that the population of the North could support such a clinic and would greatly reduce the number of patients who must travel south for radiation treatment.
Although most people tend to relate cancer to the lifesaving skills of specialists, the greater part of the work is done by primary health-care workers like family doctors, nurses and public health workers, said Chapman.

He defines the basic pattern of the cancer control strategy:
-- Prevention of cancer means management of risk factors like smoking and obesity.
-- Screening means when cancer starts. "If we can pick it up early the probability of a cure is almost 100 per cent."
-- Detection and diagnosis: "Once cancer is suspected we need to have the facilities to diagnose the type it is and how far it's spread."
-- Treatment is decided depending on what type of cancer it is, how far it has spread and the stage the cancer is at. Treatment is done by surgery, chemotherapy or radiation. "Surgery is still the most important and used form of treatment, followed by radiation therapy and then chemotherapy," said Chapman.
-- Support services include oncologists, family doctors, nutritionists, pharmacists and rehabilitation people.
-- Palliative or end-of-life care comes into play when a cure is not possible, but also offers management of pain, symptoms and complications arising from cancer to improve the quality of life.
Chapman said over the years palliative care has changed from being at death's door to more managing of pain and symptoms even with curable cancer patients.
"For example, someone with prostate cancer could have a good quality of life for 14 years while someone else with a severe brain cancer may only have a week or two. It doesn't matter how long you live as long as your quality of life is improved," he said.
"So when we talk about developing a strategy we are actually talking about developing a continuum of cancer control right from prevention to palliative care."
In the area of palliative or end-of-life care, since Prince George is the only community in the North with a hospice, each northern community must sort out the resources it has and decide how to best implement palliative care for the area, Chapman said.
Video-conferencing and telemedicine will be available in all the community cancer clinics and dietitians specializing in oncology will be available "even through video-conferencing."
"That's being developed now and we'll have to appoint that staff within the next few months," Chapman said.
Social workers will also play a strong role in the strategy's "survivorship program" that helps a patient become reintroduced to a normal life and community activities following treatment.

Copy courtesy of: Dean Birks
Royal LePage Prince George
www.DeanBirks.com
Ph: 250-612-1709