APPENDIX A: Physicians Needs Assessment Advisory Group

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<tr>
<th>MEMBER’S NAME</th>
<th>FACILITY</th>
<th>JOB TITLE</th>
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<tr>
<td>Barclay, Dr. Spencer</td>
<td>Aberdeen Hospital</td>
<td>Family Physician</td>
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<tr>
<td>Barnard, Dr. Dorothy</td>
<td>IWK Health Centre</td>
<td>Pediatric Oncologist</td>
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<td>Bentley, Dr. Jim</td>
<td>QEII Health Sciences Centre</td>
<td>Gyne Oncologist</td>
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<td>Cussen, Dr. Michael</td>
<td>Hants Shore Community Health Centre</td>
<td>Family Physician</td>
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<td>Dorreen, Dr. Mark</td>
<td>QEII Health Sciences Centre</td>
<td>Medical Oncologist</td>
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<td>Farrell, Dr. Gerry</td>
<td>Aberdeen Hospital</td>
<td>Family Physician</td>
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<td>Fleming, Dr. Michael</td>
<td>Dalhousie University</td>
<td>Family Physician, Dal CME</td>
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<td>Gallant, Dr. Paula</td>
<td>Valley Regional Hospital</td>
<td>General Surgeon</td>
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<tr>
<td>Gray, Dr. Jean</td>
<td>Dalhousie University</td>
<td>Associate Dean, Dal CME</td>
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<td>Harrigan, Dr. Lynne</td>
<td>Valley Regional Hospital</td>
<td>Internal Medicine</td>
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<tr>
<td>Leahey, Dr. Shelagh</td>
<td>Yarmouth Regional Hospital</td>
<td>Chief of Staff, Family Physician</td>
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<tr>
<td>MacCormick, Dr. Ron</td>
<td>Cape Breton Regional Healthcare Complex</td>
<td>Director of Medical Oncology</td>
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<td>MacCormick, Dr. Shaun</td>
<td>District Health Authority #4</td>
<td>Acting Medical Director, District 4, Family Physician</td>
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<td>Mulroy, Dr. Liam</td>
<td>QEII Health Sciences Centre</td>
<td>Radiation Oncologist</td>
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<td>Murray, Ms. Anne</td>
<td>Cancer Care Nova Scotia</td>
<td>Education Coordinator</td>
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<td>Padmos, Dr. Andrew</td>
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<td>Associate Dean, Cancer Programs</td>
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<td>Cancer Care Nova Scotia – Commissioner</td>
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<td>Sargeant, Ms. Joan</td>
<td>Dalhousie University</td>
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<td>Sellon, Ms. Marlene</td>
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<td>Cancer Care Nova Scotia</td>
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<tr>
<td>Simpson, Ms. Judy</td>
<td>QEII Health Sciences Centre</td>
<td>Coordinator, Palliative and Supportive Care, CCNS</td>
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APPENDIX B: District Cancer Program

One of the goals of Cancer Care Nova Scotia is for Nova Scotians to have the same standard of cancer care across the province. No matter where you live in Nova Scotia, you should be able to receive the same high quality care.

To this end, Cancer Care Nova Scotia (CCNS) is working on an overall provincial cancer system for adults and children. Each District Health Authority in Nova Scotia will have a District Cancer Program (DCP). These programs will form a network of cancer services across the province.

The District Cancer Programs will bring cancer prevention, screening, diagnosis, some types of treatment, support and palliative care closer to home for all cancer patients — adults and children. Patients will continue to go to the Cancer Centres in Halifax and Sydney to receive some kinds of treatment like radiation, and specialized chemotherapy and surgery.

To reduce travel by patients, some districts have opened outreach clinics, in partnership with the Cancer Centres, where oncologists (cancer doctors) can see patients. District Cancer Programs will only be successful if they are supported by the health professionals, volunteers and people who live in the districts.

CCNS staff have been to all of the districts to meet with key people to discuss our ideas for DCPs.

Public meetings were also held in each district in the fall of 2001 and spring 2002. At these meetings, CCNS staff presented information about our work. Participants were able to tell us how they see our ideas working in their districts.

Another early step towards developing DCPs will be to bring together the many people and organizations that provide cancer services in each district. We believe that gaps in service and duplication of services can be reduced if the people who provide cancer services work together towards common goals. One way this may happen is through District Cancer Committees. It will be important for patients and families to be part of these committees.

Pictou County Health Authority and Colchester East Hants Health Authority have already taken the first steps towards establishing District Cancer Committees.

For more information, please contact:
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APPENDIX C: Summary of literature search

Cancer Screening and Preventive Counseling

Screening tests
Five needs assessment studies focused on cancer screening and detection, four of which were conducted in the United States and one in Australia. Three of these studies examined physicians’ current attitudes and cancer screening practices. Based on self-reports, it appeared that at least 90% of physicians were performing pap tests, breast physical, digital rectal, and prostate examinations. However, Holleb (1985) reported, with the exception of breast physical examinations and Pap testing, less than half of these physicians were following the screening guidelines recommended by the American Cancer Society (ACS) for early detection. Many physicians were not performing these tests at the recommended frequency or with the recommended age groups. There was a tendency for physicians to do these tests more for patients between the ages of 50 to 75 and not at the recommended level for those who were outside of this range (Constanza et al., 1993).

By 1989, 80% of physicians reported that they were screening more asymptomatic patients for cancer than they did five years earlier. Moreover, according to Holleb (1990), more physicians were following the ACS’s guidelines in 1989 than in 1985. For example, there was an increase from 11% to 37% of physicians who followed the published guidelines for mammography. By 1993, over 80% of physicians reported that they routinely performed these tests to asymptomatic patients. These findings indicate that there has been a significant increase in the frequency with which physicians perform screening tests to asymptomatic patients and an increase in their compliance with the American Cancer Society’s guidelines (Holleb, 1985 & Holleb, 1990).

Preventive counseling
Some of the needs assessments also explored physicians’ attitudes and current practices with preventive counseling. Family physicians reported that they counsel patients about smoking cessation, nutrition, and breast self exams. Counselling about skin cancer was also done, but not as frequently. Although most FPs indicated that they provide preventive counseling, the frequency that they engaged in reinforcement practices with their patients (e.g., advise patients to eat vegetables, or prescribe nicotine gum) were shown to contradict their reports as they often did not advise these behaviours (Constanza, 1993). Generally, physicians were positive about counseling, but they also identified several barriers that interfere with their ability to counsel: lack of patient educational materials, lack of reimbursement for the time it takes to counsel, and also, some felt they lacked counselling skills (Constanza, 1993; Holleb, 1990).

Educational needs
Three needs assessments explored physicians’ educational needs and interests with respect to specific screening and detection practices, i.e., breast and skin cancers (Constanza, 1993; Lane, 1989; Ward & Macfarlane, 1993). In the Constanza (1993) assessment, physicians indicated that they would benefit from a comprehensive course that emphasized relevant recent basic research and clinical evidence, as well as practical knowledge about cancer detection and prevention. They also thought it would be useful to complete a course in improving office management to make cancer screening more efficient.

According to Lane and Burg (1989), topics of greatest interest for Continuing Medical Education (CME) included improving patient compliance, risk factors, and patient education. There also appeared to be a need for improving patient communication and physicians’ patient education skills to enhance compliance, especially since 45% of women who never had a mammogram...
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reported that their family physician never recommended it. It was also suggested that some physicians may need some education with practical hands-on skill training.

Ward and Macfarlane (1993) conducted a needs assessment to identify educational needs in the areas of skin cancer prevention, early detection and management for the purpose of planning a seminar about skin cancer for general practitioners. Physicians reported a need to learn about recognizing early melanoma and reviewing the basic clinical skill of total skin examination.

Palliative care
Four needs assessments examined physicians’ current practices, perceived educational needs related to palliative care issues and preferred learning methods. These studies were conducted in Australia, Saskatchewan, the United Kingdom, and British Columbia from 1993 to 2000. The following learning needs were identified:

According to Haines et al. (1993), physicians in Regina, Saskatchewan indicated that their learning needs were pain assessment and management, symptom control, community resources, and communication. Although family physicians also recognized a need for communication and emotional support, they did not translate this into a priority for physician learning.

Higginson’s (1999) needs assessment identified the following learning needs for physicians in London, UK: improved communication, liaison, and information between health care professionals; pain and symptom management (guidelines on drugs to use); details of available equipment; also family physicians may have limited information about available services.

Samaroo’s (1996) needs assessment in Vancouver, BC, examined physicians’ and nurses’ perceived educational needs related to death and dying. They indicated that their top education needs for providing quality palliative care were: programs that focus on the dying process; patient pain, symptom and comfort control, and interdisciplinary communications between the patient, family and caregivers.

Wakefield et al. (1993) identified a need for continuing education, for South Australian physicians, in the areas of pain and symptom control, dealing with patients’ psychosocial needs, and in bereavement counseling. Based on these findings, Boakes et al. (2000) developed and implemented a 14 week training program, using a hands on approach, to improve family physicians’ knowledge and skills in palliative care. They concluded that “the development of experiential educational programs should be fostered, especially in areas such as palliative care, where communication, crisis intervention, and compassionate caring are as important as the knowledge of complex symptom syndromes and their management” (p.18).

Surgical oncology networking
Cancer Care Ontario conducted a needs assessment in 1999 with general, specialty and oncology surgeons to examine their current networking practices and learning needs in an effort to enhance the Surgical Oncology Network strategic plan. The majority of respondents (94%) reported that they had adequate access to colleagues for consultation purposes related to surgical oncology issues. However, since the database of surgical oncologists was not very highly endorsed, Cancer Care Ontario indicated that they need to highlight and promote its usefulness. A need was also identified for promoting the usefulness of standards of care and
outcome measures as surgeons appeared to be uncertain about the value of these concepts. Ontario surgeons only expressed a mild interest for the educational topics provided, 65% were in favour of evidence-based decision-making and 60% for critical appraisal.

Conclusions from the literature review:

- A small number of studies of physician practices, attitudes and learning needs related to cancer screening, preventive counseling and palliative care were reported. We considered the methods and results of these studies in the development of our tools.
- Needs assessments related to physician screening and detection practices have not been conducted since 1993.
- Only a couple needs assessments have examined the current practices and educational needs of Canadian physicians.
- There have been no comprehensive needs assessments reported that have examined current practices and learning needs of physicians with regards to the whole spectrum of cancer care (i.e., screening, prevention, diagnosis, treatment, follow-up, and palliative care)
- In light of this, there is an opportunity for this Cancer Care Nova Scotia and Dalhousie Continuing Medical Education physicians’ needs assessment to make a significant contribution to the literature as it addresses the whole spectrum of cancer care. It will provide up-to-date information about physicians’ current practices and learning needs, and it will specifically address the needs and challenges of Nova Scotian physicians.
REFERENCES


APPENDIX D: Oncologist and Cancer Specialist Interview Questions

Introduction: CCNS is conducting a needs assessment of the learning and support needs of family physicians and community based specialists in the provision of cancer care. To accomplish this, we have asked physicians in NovaScotia to complete questionnaires identifying their own learning needs. We also wish to interview oncologists and cancer care specialists who receive referrals from family physicians and community based specialists to learn their perceptions of the learning and support needs of these physicians with regard to cancer care and the best way to meet them.

1. Based upon your perspective as an oncologist/cancer specialist and the frequency and types of referrals you receive from family physicians, what kinds of needs or gaps in care do you see that might be addressed by education?

   1.1 Prompts:
   Do you see particular education needs in these areas:
   - Cancer prevention?
   - Screening?
   - Diagnosis?
   - Treatment?
   - Follow up?
   - Palliative care?
   - Other?

   1.2 Prompts: Do you see particular education needs in skills development (e.g.: communication, chemotherapy), or attitude changes (e.g.: about screening practices)?

   1.3 Prompts: Do education needs for community based specialists differ?

2. Do you think the learning needs of family physicians and community based specialists differ between the nine district health authorities? If yes, in what ways?

3. What would you suggest as the best way/s to meet these specific needs of family physicians?

   3.1 Prompts:
   What kinds of methods of providing information and education would you suggest:
   - Workshops?
   - Internet?
   - Case studies?
   - Lectures?
   - “Helpline” to an oncologist?
   - Preceptorships?
   - Checklists for continuing care of patients?

   3.2 Prompts:
   Do the ways to meet the education needs of community based specialists differ?

4. What do you see as the role of oncologists in meeting these needs?
4.1 Prompts:
- Should oncologists provide all or some of the education sessions?
- What support would you need to do this? (e.g.: locum, compensation, logistical support)
- Are you willing to travel?
- Who else could provide these education sessions?

5. The following two questions address concerns identified by family physicians and/or patients in the care of cancer patients. One problem identified was the long waiting period from the time of referral to the time of cancer specialist appointment. Do you perceive this as a problem? If so, what suggestions would you make to improve or prevent this problem?
   What supports or resources are needed to implement these suggestions?

6. Family physicians also indicated that they believed that better communication with cancer specialists about their patients could improve cancer care. What are your thoughts about this? What suggestions would you make to improve communication?

6.1 Prompts:
- Family physicians identified that checklists and/or an oncologist helpline would be helpful to them. What do you think of these suggestions?
- Is it realistic to expect oncologists and cancer care specialists to develop/provide these services?
- What kind of supports would you need to provide these services?

7. CCNS is implementing a District Cancer Program, a community-based model for caring for patients in their community. To enable patients to be treated closer to home, it has been suggested that a part-time Medical Coordinator, with specialized education in cancer care, could play a supportive role in each District Health Authority. Have you heard of this? What would you see as the role of this position?

7.1 Prompts:
- What would you see as the role of an oncologist in this model?
- What would you see as the role of family physicians in this model?
- What would you see as the role of community-based specialists in this model?

8. Are there any other comments you would like to make about physician learning or support needs in caring for patients with cancer, and ways to address them?
APPENDIX E: CCNS Patient Navigation Qualitative Study Executive Summary

The findings of Cancer Care Nova Scotia’s (CCNS) Patient Navigation Study indicate that cancer patients and their family members are generally satisfied with the medical treatment they received once a cancer diagnosis was confirmed. Despite this positive finding, it is evident that improvement is needed relating to the initial diagnosis process and the non-medical aspects of cancer treatment. Perhaps most importantly, results suggest that CCNS should consider adopting a multi-disciplinary approach to the provision of cancer care service that addresses the medical, emotional and financial needs of those affected by cancer. Findings also confirm that there is a need for a service coordinator, similar to the patient navigator concept.

The family doctor’s role during the initial diagnosis stage of the journey was viewed as problematic. Many patients were required to wait an unacceptable length of time before they received their diagnosis and in some cases, family doctors were seen as dismissing the concerns of their patients. Similarly, with regard to the initial diagnosis, the manner in which patients were informed that they had cancer was not always appropriate, with some learning of their diagnosis through a telephone conversation. All stakeholders viewed continuing education for family doctors, specifically in the area of oncology, as paramount to overcoming this issue. Likewise, establishing a standardized manner for which patients can learn of their diagnosis in person will also assist in improving service in this area.

Stakeholders also identified the need to heighten the family doctor’s role in the treatment process. Currently, once the initial diagnosis is made, the family doctor generally loses contact with the patient and is unaware of the patient’s treatment regime and progress. This creates an uncomfortable situation for both the patient and the family doctor when the patient is required to return to his/her family doctor for follow-up. Including family doctors throughout the entire journey would have great value and this was evident in those cases where the family doctor did take an active role.

Results suggest that a greater emphasis is needed on the non-medical aspects of cancer care. Patients and their families need assistance in adjusting to the diagnosis. They require someone to whom they can turn to get answers to their questions and concerns. There is a desire for a neutral party to whom they can talk to informally and who can affirm that the thoughts and feelings they are experiencing are normal. Many patients would also like to have the opportunity to meet with other people who have a cancer similar to their own. In these instances, patients and their families require assistance in accessing the supports that are available to them. Patients and their families need a central person who can put them in contact with the person and/or service that they require at any point in time.

Finally, patients and their families noted a financial burden associated with cancer that the system does not currently address. Most notably, people residing in rural parts of the province have to incur costly transportation and accommodation costs. In instances where patients do not have private health coverage, the costs associated with anti-medics, certain adjunct therapies and medical supplies can be quite costly. These costs are compounded when there is a loss of income due to a temporary exit from the workforce as a result of having cancer. Patients and their families need assistance in overcoming these financial issues and in getting in contact with the appropriate agencies to address these and other financial issues.
APPENDIX F: Specific topics identified for CME programs by community specialists

Grouped by General Topics:

CHEMOTHERAPY

Pediatricians: Side effects; Mechanism of action

Obs/Gyn: Update on gyne Rx; Newer ovarian drugs & results

Surgeons: Side effects (2); Current standard for Rx; Clinical trials available; Neoadjuvant treatments; Interferon & melanoma; Effects on wound healing; Melanoma; Breast cancer; Colon cancer; Success rate; What studies are ongoing

Internists: Long-term side effects; Colorectal; Gastric cancer; Managing blood products; Other GI; Colon cancer; Which agents to use in what malignancies; What to observe as complications; What to observe as complications; Lung cancer

SURGERY

Pediatricians: n/a

Obs/Gyn: Updates; Complications of surgery; Indications; Early endometrial Ca; Early cervical Ca

Surgeons: DCIS – Breast; Breast cancer elderly/infirmed; Latest innovation; How effects of surgery relate to adjuvant therapy; Limb salvage vs. amputation; Recommended margins; Current melanoma guidelines; New recommendations; New technology - sentinel node laparoscopic surgery; "How I do it"; Trick of trade/post-op Management; Breast cancer; Skin cancer; Does it help?; After effects; New technologies & equipment; Melanoma surgery; Cutaneous malignancy; Malignant melanoma

Internists: Colon cancer

HORMONE THERAPY

Pediatricians: n/a

Obs/Gyn: Indications; Benefits; Relating to breast cancer; Role in therapy; Role in causation/prevention; Pros/cons of; HRT in CaBr/CaOr/CaHT (?)

Surgeons: n/a

Internists: Little knowledge of this - any education would be welcome
### RADIATION THERAPY

**Pediatricians:** n/a  
**Obs/Gyn:** Updates  
**Surgeons:** Role to play skin cancer; Are local standards etc. uniform with international standards?; Is it needed?; Side effects; Who gets what; In breast cancer; In rectal cancer; What is being used as opposed to what is reported in literature; Different protocol/studies; Colorectal cancer; Treatment of cutaneous skin cancers; XRT for SCC/BCC; Recommended doses; Guidelines for use  
**Internists:** Lung cancer

### ADJUVANT THERAPY

**Pediatricians:** n/a  
**Obs/Gyn:** Updates; Effectiveness; Family involvement; What are the alternatives?  
**Surgeons:** Combination Rx for Ca prostate; Salvage Rx for Ca prostate/bladder; Colon cancer; Malignant melanoma; Consensus?; Recommendations; How it relates to surgery; How to communicate "%" to patients; What's new  
**Internists:** Use of WBI stim agent; Depression; Colorectal; Other GI; Colon cancer

### ALTERNATIVE & COMPLEMENTARY THERAPIES

**Pediatricians:** n/a  
**Obs/Gyn:** Avoidable modalities; Effectiveness; Diet; Vitamins, herbs, etc; What are the alternatives?; Updates  
**Surgeons:** Reference to skin & breast carcinoma; Toxicities; What is available/used by patient; What is potential side effect; Availability; FDA approved?; Standards vs. "shot in the dark"  
**Internists:** What are patients taking; What can happen; Proven therapies; Risks & adverse effects

### PAIN MANAGEMENT

**Pediatricians:** For procedures; Chronic pain  
**Obs/Gyn:** Have morphine pumps; Oral meds/trying to avoid SE's; Updates  
**Surgeons:** Pt controlled analysis; Nausea management; Terminal care; In hospital; As an outpatient; Chronic/dysesthetic pain; New pharmacology  
**Internists:** Tx depression; When to refer – where; Most physicians have limited knowledge
SYMPTOM MANAGEMENT

**Pediatricians:** Nausea etc. (2); Nutritional concerns; Febrile neutropenia; Anorexia

**Obs/Gyn:** Most distressing symptoms; Treatments for managing symptoms; Post-treatment Rx; Menopausal sx when HRT not indicated; Pelvic pain; Chronic pruritis

**Surgeons:** Specific to melanoma; The role of the palliative care team; Recurrent obstruction; Fatigue; Pain control; Nausea control

**Internists:** Pain (2); Management of cancer-related cough; Management of dyspnea; Depression; Nausea

SUPPORTIVE & PALLIATIVE CARE

**Pediatricians:** Pain management; Psychosocial aspects

**Obs/Gyn:** Fatigue; Emotional support for families

**Surgeons:** Death with dignity; Living wills; Community & hospital; Recurrent breast cancer; Unresectable/untreatable cancer; How to measure "quality of life"; How to say "Enough is enough."; Use of surgery in palliative care patients

**Internists:** Pain management; Bowel care

ONCOLOGIC EMERGENCIES

**Pediatricians:** n/a

**Obs/Gyn:** Vaginal bleeding = ca

**Surgeons:** Spinal mets with acute symptoms; Treatment for chemo toxicity; List willing to take calls; Febrile leukopenia; Bone metastary calcuiucines; When & what to watch for; Which test to confirm the problem; Recognizing them; Treating them

**Internists:** Hematologic malignancies, eg blast crisis; Clotting problems, eg with prostate cancer; Acute leukemia; Neutropenia; Management of complications; Precautions to observe in pts on chemo & other; Febrile neutropenia; Decreased level of consciousness

Other

**Obs/Gyn:** Surgical updates; Medical updates

**Internists:** Management of depression; Psychiatric manifestations
APPENDIX G: Education Advisory Group Terms of Reference & Membership

Accountability: The Education Advisory Group is accountable to the Executive of Cancer Care Nova Scotia.

Membership: The membership will be balanced amongst cancer specialists, health professionals, consumers, and educational experts. Representation will strive to reflect the geographic diversity of the population with the majority of the members coming from the District Cancer Programs. An Advisory Group Chairperson will be appointed by the membership.

Purpose: The Education Advisory Group will advise Cancer Care Nova Scotia, through the Education Coordinator, on educational programs for Health Professionals.

Liaison: The Education Advisory Group will liaise with other provincial cancer programs such as the Nova Scotia Breast Screening Program and the Hereditary Cancer Screening Program.

Responsibilities:

- To provide advice and leadership on the development and implementation of evidence-based and best practice educational programs in cancer for health professionals working at the primary, secondary and tertiary levels to ensure a quality-driven cancer system. Education programming should address the entire cancer spectrum from prevention to palliation.
- To advise on the following aspects of health professional education: needs assessment, program development, program implementation, and evaluation.
- To develop strategies to ensure equitable access to educational opportunities for all levels of health professionals, regardless of geographic location.
- To ensure that, where possible, education programs are based on the Standards of Care available for each health professional organization.
- To work co-operatively to promote interdisciplinary educational opportunities.
- To facilitate the recruitment of mentors to work with health professionals during their learning journey.
- To advise the Communication and Education Coordinators on the professional section of the Cancer Care Nova Scotia web site.
- To work in cooperation with provincial, national and international cancer programs in order to promote cancer care education.

Meetings: Meetings of the Education Advisory Committee will be held four times a year. Additional meetings will be held as required.

Voting: Decisions will be reached by consensus.

Reporting: The Education Advisory Group will report through the Education Coordinator at Board Meetings. In addition, the Group shall submit an annual report on its accomplishments and future initiatives to the Commissioner of Cancer Care Nova Scotia.


Term: The term of membership will be two years with half the membership being replaced each year. The accomplishments and Terms of Reference will be reviewed on an annual basis, each January.

The term of office for the Advisory Group Chair will be two years. A new chair will be appointed six months before the current chair retires.

Education Advisory Group Membership List:

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<tr>
<th>Name</th>
<th>Title</th>
<th>Area</th>
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<td>Palliative Care Nurse</td>
<td>St. Martha’s Regional Hospital</td>
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<td>Lisa Bourne</td>
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<td>Dorianne Rheume</td>
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<td>Shelley MacDougall</td>
<td>Consumer</td>
<td>Sydney</td>
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<td>Sher Clain</td>
<td>Family Physician</td>
<td>Bridgewater</td>
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<tr>
<td>Donna Grant</td>
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<td>Anne MacCormick</td>
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<td>Deborah Gillis</td>
<td>Oncology Nurse</td>
<td>Cape Breton Cancer Centre</td>
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<td>Ethel Ells</td>
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<td>Michelle Kucey</td>
<td>Manager</td>
<td>Nova Scotia Community College</td>
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<td>Jill Skinner</td>
<td>Pharmacist</td>
<td>Colchester East Hants Health Authority</td>
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<td>Joan Sargeant</td>
<td>Director</td>
<td>Dalhousie CME</td>
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<td>Mary Lou Ellerton</td>
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<td>Terry March</td>
<td>APPHON Coordinator</td>
<td>IWK Health Centre</td>
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<tr>
<td>Theresa Marie Underhill</td>
<td>Chief Operating Officer</td>
<td>Cancer Care Nova Scotia</td>
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<tr>
<td>Anne Murray</td>
<td>Education Coordinator</td>
<td>Cancer Care Nova Scotia</td>
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<tr>
<td>Kristina Allsopp</td>
<td>Secretary</td>
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