

Psychosocial Supportive Care: An Effective and Integrated Team Approach
APOS 6th Annual Conference
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Slide # 1 Thanks to the organizers for the opportunity to once again speak at the APOS annual meetings. I acknowledge the ongoing work of my own colleagues at the PEI Cancer Treatment Centre. You might be interested to know that our multi-disciplinary office is truly in the middle of the centre ... for patients, doctors and other staff.

I also thank Julie Cole, the chief librarian in our hospital, who is of such fine research help. Also, may I acknowledge the great research conducted in our psycho-oncology field through IPOS, APOS and CAPO, so valuable for those on the front lines, continually attempting to upgrade cancer care practice.

#2. Supportive care collaboration, from diagnosis to palliation, is an approach that improves the quality of life of patients and their families facing the problems associated with cancer driven illness. Actually, the collaborative tent is large, covering everyone from the primary oncologists through to reception staff, nurses and the multidisciplinary teams. The best practice efficacy of the multidisciplinary approach is widely documented.

#3. By the time the patient reaches the treatment centre, disease stress and anxiety have usually peaked. We do all we can to ease the transition into the clinic practice. We've even had our music therapist program the waiting room background sound (not elevator music!) But, in a perfect world, it would be great to have our services begin in conjunction with the family docs.

#4 Any chaplain might tell us that there are those who still think that anything else but medical/radiation oncology is peripheral. Spirituality too has its place. J Pastoral Care & Counseling, Winter 2006 Vol60, No.4:395 "...79% of US adults (1000 survey) believed that spiritual faith can help in disease recovery, and 64% felt that the topic of spiritual faith should be broached by physicians." [In one survey 45% of nonreligious patients thought physicians should inquire politely about patients' spiritual needs. BMJ v 325 21-28 Dec 2002:1434 *Patients and physicians have begun to realize the value of elements of faith, hope, and compassion in the healing process.*]

#5. Effective Supportive Care: Physical and psychological/ spiritual-emotional distress; Total pain (existential); Skill in pain/drug/cogency; Family dynamics (and financial issues). Distilled to four basics, the team will be able to reflect these skills for treatment throughout the patient's journey.

#6. PROFESSIONAL ARTISTRY & TECHNICAL COMPETENCE: Pain concerns; Fears of the future; Need to screen for emotional, family and spiritual distress; Patients suffer ... and so do families! The challenge for psycho-oncologists and supportive care professionals is to have the appropriate tools to treat these 'emotional/spiritual' reactions. Tools are available, but how widely used are they in the fast pace of a busy clinic?

#7. SPIRITUAL/ EMOTIONAL/ SOCIAL. Unsettling questions for patient and family: "Why is this happening?"; "Why me?"; "Is there any sense in this?" "How will I/they cope?" The myriad of losses accompanying the person with cancer is in the concern domain of every team player ... but these questions are held in tension with treatment modalities. A specialist may be required to handle any of these reactions when severe.

#8. All of us require "meaning" ... I used to prescribe Viktor Frankl's well-known *Man's Search for Meaning*.

#9. SYMPTOMS OF DISTRESS: FEAR; PAIN; ANXIETY; CONFUSION; DEPRESSION; ANGER; HOPELESSNESS; LOSS; APATHY; SHAME; GUILT; REGRET; WITHDRAWAL; ISOLATION; RESENTMENT; DISBELIEF; CONFLICT; LONELINESS; POWERLESSNESS

In our environment – the oncologists and we ourselves think in terms of “supportive care”. These are emotional, existential and spiritual matters. Mounting empirical evidence describes the emotional/spiritual needs of patients with cancer, and their families. Pain is one of the most feared side-effects of cancer, both pt & family. I am required to attend pain clinics. Existential or total pain, if not seen and treated as such, can lead to chemical toxicity if treated only as physical pain. I frequently use the HADS instrument to determine anxiety and depression levels – especially for charting and interprofessional referrals.

#10. Serenity and Spiritual Calm: One of our team members, in high demand, is our qualified music therapist. Very positive outcomes are found here, especially in palliation.

#11. CONTINUITY OF DEEP TEAM CARING: *Increased QoL; Smoother transitions; Less duplication; Shorter hospital stays; Increased emotional, social, spiritual support Extends beyond patient; Pharmaceutical & nutritional inputs/controls; Improved pain and treatment management; Patients remain in contact with carers; Transition to palliative care team; Positive cost-offsets.* We have found that all the above result from an integrated collaborative program. Literature and our experience also indicates a better wellness level for the professional care-givers.

#12. Members of the team realize that other post-hospital or clinic supports are clearly indicated.

#13. Do these psychosocial supports increase medical costs? NO. See Linda Carlson and Barry Bultz’ well known ‘Efficacy and Medical Cost Offset of Psychosocial Interventions in Cancer Care: Making the Case for Economic Analyses’ There is a decreased overall cost burden to health care system... emotional/spiritual supportive care is essential to health, may be positively cost-effective.

#14. Team members Present for New Patient Assessment Rounds: *Oncologists (Radiation and Medical); Manager, Radiation Department; Social worker; Nurses; Spiritual Care Clinician; Nurse practitioner; Dietician; Pharmacist; General practitioner; Medical Secretary; Radiation Secretary; (Music therapist).* *The team meets each Monday. Every patient is team reviewed/assessed, to optimize treatment modalities. Included in the chart is the “4Cs Assessment Tool”.*

#15. A psycho-oncology ASSESSMENT TOOL: There are many assessment instruments and several ways of assessing patients. One which we have successfully used has helped the docs and others in their treatment plan. *It is the 4C's emotional and spiritual self-assessment (Cancer, Coping, Comfort, Community). This instrument gives a snapshot, not a quantifiable measurement; simple, accurate, patient centred; Proven useful, helpful, friendly and well-received; included in the patient's chart.* To view it, see www.strathmor.com/4Cs.html. If it’s helpful in your practice, feel free to use it.

#16. Concluding Reflections: *Does size count? We're small, we see about 100 patients a day, plus another ten to twenty in the acute care hospital. The literature speaks of the need for a team builder, a 'champion'; * Time/cost management - sharing saves everyone 'time'... 'money'; Optimize patient care, improve outcomes, best practice provision; Improved patient satisfaction; Collaboration medical & radiation; streamlined referral pathways.*

*A ‘champion’ is the creative driving force, fostering a positive atmosphere and focuser of clear goals. Our Cancer Treatment Centre is relatively new ... from the beginning this was the model created through our ‘champion’ Liz Dobbin, the Cancer Treatment Centre’s manager!

#17. *More reflectionsCommon documentation process; Care delivery in accordance with professional guidelines, including psychosocial standards; Clinical interaction, and education; Benefits spread to all activities (beyond our Centre); Increased collegiality; Enhanced educational opportunities. IMPROVED STAFF WELLNESS.* - Improved staff wellness... put another way – more fun, more interaction, lots of professionalism and yet no blurring of professional boundaries!!

#18. Thanks for your interest!!! Dr David Morrison. PEI Cancer Treatment Centre, Canada.
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This presentation is a reflection of an actual hands-on practice, and it is evidence based. One comprehensive bibliography can be found on the web at
http://www.canceraustralia.gov.au/media/14733/multidisciplinary_care_and_managed_clinical_networks_resources.pdf