

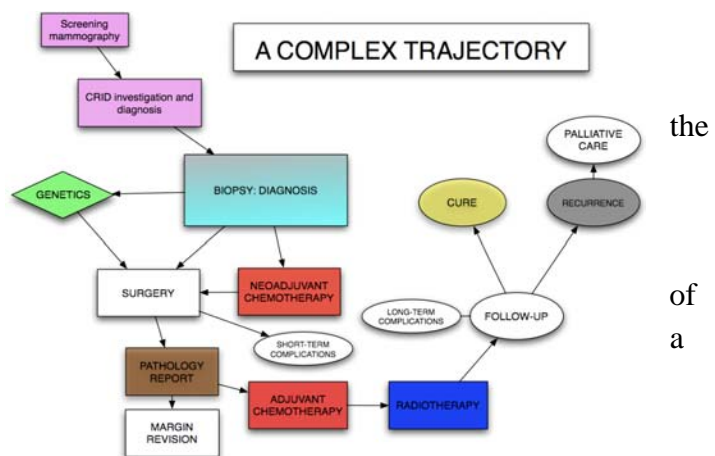
Why do we take care of others? In Team Work

by Marc Basik, MD and Carole Seguin, RN

Although the term « multi-disciplinary team » has become quite popular in recent years, and is now recognized as the standard of care in clinical oncology, the actual creation of such a team is not a simple undertaking. Obstacles include the lack of trained personnel, old prejudices and lack of resources. In this short presentation, we will describe how a multi-disciplinary team was born at the Segal Cancer Center of the Jewish General Hospital in Montreal, Canada. The creation of this team has resulted in a synergy between its members, enhancing their ability as caregivers in the hospital milieu.

This multi-disciplinary team was conceived for the management of patients with breast cancer. Breast cancer affects 1 in 8 women in Canada, and the Segal Cancer Center sees approximately 350 cases of newly diagnosed breast cancer every year. Despite major advances in the diagnosis and treatment of breast cancer, a new diagnosis of breast cancer triggers a major existential challenge for the individual, due to the emergence of the awareness of one's mortality.

The clinical trajectory that breast cancer patients must follow after a suspicious mammography is quite complex (Figure 1). At our hospital, Breast Cancer Center is a specialized location for the investigation and diagnosis of equivocal or suspicious screening mammograms. A biopsy carcinoma leads to consultation with breast surgeon who then decides whether surgery or pre-operative chemotherapy should be the first intervention. A consultation with the genetic counsellor is requested if indicated by the family history. After surgery, the patient needs to be followed for wound care until the pathology results become available. Once these results are communicated to the patient, she can begin adjuvant chemotherapy and/or radiotherapy. Follow-up is then continued at regular intervals to screen for long-term complications and tumor recurrence.



In order to facilitate and accompany the patients' passage through this trajectory, the Health Ministry of the Government of Quebec imposed a program of « inter-disciplinary » teams in September 2006 upon all oncology clinics and hospitals managing cancer patients. Guidelines

were set by the Ministry and each hospital was to be evaluated for conformity to these guidelines by evaluation teams that would visit the hospitals. As a result, each hospital in Quebec scrambled to devise programs in conformity with these guidelines. Major hospital centers like ours that already had a well-developed cancer care program had to modify various aspects of this program as well as create those that were missing, so as to conform to the guidelines.

At this time, the two of us were asked by our respective departments to organize an inter-disciplinary breast cancer team so as to prepare for the visit of the evaluation team. We had not really worked with each other before, and we were both upset about the « imposed » character of this program, with its risk of artificially altering functioning structures in the hospital. Nevertheless we accepted with the hope that we could prepare the hospital's breast cancer team for the visit 7 months later.

As we looked at the requirements, we became somewhat discouraged. First of all, we did not have a nurse navigator, the key element in the Ministry's « inter-disciplinary » team. This person is the one that would accompany the patient through the trajectory, and thus serve as the patients' chief contact with the hospital. Carole, the head nurse of the Breast Cancer Center accompanied patients through to surgery and each patient later acquired a primary nurse for her chemotherapy visits. We identified a gap between the time of surgery and the beginning of chemotherapy that could potentially benefit from another nurse accompaniment. We decided to hire a nurse navigator, and 4 individuals later, found Marielle, whose humanity, expertise and compassion became priceless for the patients.

We did not have a psychologist attributed to the breast cancer team, although a psychologist specialized in oncology was already working in the hospital. The most problematic position to fill was that of « clinical nurse specialist », with a poorly defined task and a Master's degree in Nursing Sciences as a necessary qualification. Several months later, we were able to find such a person, indeed, a very qualified academic nurse researcher.

Next, we had to prepare a schedule of meetings of this « inter-disciplinary » team. Several kinds of meetings were expected, including one for the evaluation of difficult patient cases and another for the well-being and support of the team itself. Minutes and attendance at such meetings had to be well documented. Finally, the document containing all of the evidence of our attempts at conforming to the guidelines had to be prepared (it turned out to be a 392 page document).

In front of this difficult task, each of us made the same decision : to make this situation useful and positive for the care of our patients. Whatever we were going to have to produce should somehow be used to improve the quality of care to patients, and not to merely satisfy guidelines. In this way, we discovered in each other a mutual desire to truly serve our patients, and we supported each other in this. Indeed, a friendship was born, which was to drive this project forward towards its recognized goal : to facilitate or ease the breast cancer patient's passage through the the treatment schedule for her breast cancer. Our friendship is truly the first fruit

resulting from our acceptance of this work. Indeed, it remains the foundation on which everything else has been built to this day.

The outcome of this work is that an « inter-disciplinary » breast cancer team composed of 13 knowledgeable professionals now meets once a month to discuss complex breast cancer cases (Figure 2). Our team includes a social worker, 2 nurse navigators, a pharmacist, a medical oncologist, a surgical oncologist, a psychologist, a primary nurse, a clinical nurse specialist, a medical archivist, a lymphedema physiotherapist, a volunteer and a clinical administrator.

In the 2-3 years since the team was constituted, several things have been accomplished. First, the breast cancer patient is now truly accompanied through all facets of the treatment, without any gaps. An increase of women participating in the government-mandated screening program resulted from our efforts at community outreach. Quebec's first in-hospital, free lymphedema clinic was opened at our hospital, and is now both very popular and successful.

Moreover, the creation of the « inter-disciplinary » team allowed several innovative research projects to begin. These include the creation of a pre-operative tumor biopsy bank for locally advanced breast cancers, two new projects to decrease the incidence of lymphedema in breast cancer patients and a project investigating the role of hypnosis prior to breast biopsies.

Is there any evidence that such a team improves health care for cancer patients? Some evidence exists in the field of critical care, but very little is available in oncology. However, our experience shows that the health and well-being of our patients is improved by the cohesiveness of the team. For instance, since the nurse navigator makes herself available to all patients before and after surgery, any wound complications from the surgical procedures on the breast are diagnosed earlier than before, leading to more timely interventions. At our « inter-disciplinary » meetings, primary nurses can be helped to deal with difficult patients, and maladaptive family situations can be identified and a plan developed for their resolution.

The development of such a team challenges the ongoing hyper-specialization of medicine, by revealing the shortcomings of the model whereby a single autonomous physician cares for the cancer patient. In fact, working in a team is not easy for physicians, and even less so, when together with nurses. A change in culture is required by the « inter-disciplinary » team approach. However, it also highlights the relevance of social and human data that may be easily forgotten in the management of these patients.

However, the glue that holds it all together remains a passion for the well-being of the individual seeking our care. With this goal at heart, it becomes easier to treat team members as full participants in the work. Indeed, the team functions like a family, led by the clinical administrator (Carole) and its medical director (Mark).

