Pediatric Psycho-Oncology Longitudinal Elective: 
An Overview for Medical Students
(for use also in the Psychiatry Rotation Outpatient Experience)

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I. Description:
The pediatric psycho-oncology service provides mental health care to children and families undergoing treatment for hematological and solid malignancies in the inpatient and outpatient settings at the Yale-New Haven Children’s Hospital and Smilow Cancer Center, as well as bereavement support and other help to the professionals staffing these services. The service is staffed by a team of providers: Dr. Martin, Dr. Laurie Cardona, child psychiatry and psychology fellows, licensed clinical social workers and you, the medical student.

Your work will vary daily and can include collaborating in supportive care (listening, counseling, and even psychotherapy) for the child, family, and team throughout the course of illness; diagnosis and treatment of psychiatric conditions in a medically ill child; management of common psychiatric consult-liaison issues such as delirium and capacity evaluations; and psychosocial end-of-life care and bereavement. While this rotation is often medically, emotionally, ethically and psychosocially intense, it is just as rich and rewarding.

II. Your role:
Overview: The elective runs (at least) three months, with required attendance of one day weekly. You will attend rounds, perform consults, attend weekly psychosocial rounds, as well as “extras” coordinated by Dr. Martin. The outpatient experience, as a part of the Psychiatry rotation, runs for six weeks, with required attendance of one half-day weekly and optional “extras” coordinated by Dr. Martin.

Rounds: Students will often attend two sessions of morning rounds: 1) unit rounds at 7:30 with the heme-onc team in the charting room on 7-3 (as of July 2011, this is the pediatric hem-onc unit), and another at 8:15 at the nurses’ station in the outpatient pediatric heme-onc clinic (at the nurses’ station in 7N, in Smilow). Though you will not present patients, there is much to be gained in these rounds: learning your patients’ progress; receiving referrals, especially at the point of diagnosis; taking the overall “temperature” of the service; connecting with attendings, residents, and students; and being available to answer specific questions about a child’s psychiatric history or care. Note that you will miss the end of unit rounds to get to outpatient rounds. (You will follow Dr. Martin’s lead as to when to leave rounds).

Consultations: Throughout the day (or half-day) you will visit patients and families in both of the units mentioned above, as well as in the pediatric bone marrow transplant unit on 8W. You’ll coordinate schedules with Dr. Martin and almost always see patients together, sharing the responsibility for interviewing patients and families. You may be asked, or you may ask, to follow up on patients by yourself.

Write notes on every substantial patient contact, no matter how brief or unrevealing; the primary teams rely on knowing we are present, and appreciate the documentation.

Conferences (for elective students): You will also be invited to join interdisciplinary psychosocial rounds, currently held on Thursdays at 3pm in the Pearson room on the 7th floor between West and South pavilions. These are high-yield team discussions—the “tumor board” of
psychosocial oncology. Speak up if you know a patient well, or have a burning question. Most everyone in the room is very welcoming of students. After these rounds you are usually free to leave.

You may also be invited to Child Psychiatry C-L Fellows’ Rounds (once a month on Thursdays at 9am or Fridays at 10:30), Schwartz Rounds (interdisciplinary psychosocial provider rounds held at Smilow once a month on Thursdays at 12pm), PACT (Parenting at a Challenging Time) consultations, and possibly more. You may be asked to present to students, fellows and faculty at Sam or C-L Rounds. These are supportive educational settings in which you can explore a topic of your choice.

III. Goals
• Become familiar with the goals and techniques of supportive psychosocial care, and understand common stressors at diagnosis, during treatment, and in end-of-life care
• Understand common psychiatric presentations in childhood cancer (e.g. steroid-induced mood and behavioral disorders, delirium in in the brain tumor patient) and approaches to treatment
• Involve yourself in many aspects of care, including Child Life, Social Work, Palliative Care and Ethics Consultations
• Familiarize yourself the strong reactions which you will inevitably have in this milieu, and learn to work with others to help dissipate them

IV. Three Sample Consultation Notes
*Note – if completing the Psychiatry Outpatient 6-week Experience – you will likely interview patients together with Dr. Martin and may not gather all of the information presented in the notes below. As said above, simply put in the note all relevant information that is gathered, it provides insight to patient care that the primary team values. Your note can be written as a “Progress Note – Student – Psychiatry” in SCM.
Look through previous Social Work, Child Life and Psychiatry notes for background.

1. An Initial Consultation

HPI:
Joe M. is a 10-year-old 5th grader at Greenwood Elementary School in Superb, CT who was diagnosed with pre-B cell ALL last week after complaining of leg pain and experiencing a 10-pound weight loss for one month. Initial diagnostic studies showed that he has low-risk disease, including no CNS disease, though he is part of the high-risk arm of COG protocol AALL 0232 because of his advanced age.

Background:
Joe was the healthy product of a full-term delivery, and his development is reported to have been normal. He has had no medical problems, and his behavior has only become problematic at home this year, which his mother attributes to her recent divorce. He continues to perform well in school, receiving top grades. He plays baseball on a regional traveling team, and trumpet in an after school music program. Joe is a single child who lives mostly with his mom, a full-time employee of an accounting firm, but spends weekends with his father, who is reported to have some history of depression and substance abuse. There are no other mental health problems reported in his family. His parents report no religious preferences, though they are of Catholic
heritage. They have no experiences of childhood cancer, nor serious childhood illnesses, in their family or community.

Consult:
Joe was lying in bed, dressed in Transformer pajamas, watching cartoons. He was accompanied by his Mother, Joanne, while his father was at work. Joe was reluctant to talk with us, making poor eye contact. His affect was withdrawn and flat. Joanne was welcoming and eager to talk, appearing tearful and sad. She felt “overwhelmed” by her son’s cancer diagnosis, saying that she had “more than I could handle already” with her recent divorce. She accepted our offer to speak alone, and elaborated on her tension with her ex-husband, who she reports to be a “twenty year alcoholic” but who she said “has been present since the first moment we set foot in his horrible place.” She says that his presence will be good for Joe—they have a strong bond and “he doesn’t see enough of his Dad.”

Joanne also complained that word of Joe’s diagnosis had travelled quickly at his school, and that many parents “who I hardly even know have offered to bring food, when my own sister doesn’t even know yet.” She describes herself as private, but someone who has a few close friends who she has been relying extensively this week.

Joe himself initially said his cancer diagnosis was “ok,” but upon further questioning, he said that he was afraid that he might die “like grandpa,” who apparently passed away the year before, something that Joanne said “crushed” her and possibly contributed to her divorce. Joe’s knowledge of biology seemed basic, but he was receptive to an explanation of cells and growing out-of-control.

Assessment:
Joe is a 10-year-old boy with newly diagnosed ALL. Psychosocially, his family experience da recent divorce, although all parties seem to be collaborating productively on supporting Joe at this time. Relevant points of intervention include educating him about his diagnosis and treatment, and providing anticipatory guidance about possible side effects of treatment and its effects on his school and extracurriculars, as well as supportive care for his family members.

Plan:
1. Will connect with his father to introduce our service
2. Suggested that family start a CaringBridge.org page, or appoint an “information minister”
3. Will collaborate with Chid Life and others in assessing and furthering Joe’s understanding of his disease, and willingness to take part in directing his care
4. Child life can provide school visit to educate classmates and teachers when appropriate
5. Will follow up weekly with him as inpatient, and weekly in Thursday clinic
6. Request educational consultation about home tutoring before discharge
7. Joanne has our contact information should she wish to call at any time

Please call with any questions or concerns, or request for further contact with the patient and his family.

Pediatric Psycho-Oncology Service
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2. Progress Note #1 (a quick “for the record” note)

Update:
Today we visited with Sarah A. as she was preparing to leave for an MRI. She said “I am not in the mood to talk” and appeared anxious and withdrawn, lying in her bed with the covers pulled up to her neck. She was not accompanied by either of her foster parents, who were at work. She accepted our offer to return later in the week to talk.

Assessment:
Sarah is a 13-year-old girl with osteosarcoma, who was admitted for scheduled chemotherapy. We have been following her for three months because of difficulty coping with daily life in the care of her foster parents, after being placed there by DCF in 2009 at the time of diagnosis because of medical neglect. Her recent complaints have included now-worsening knee pain and confrontation with her biological parents during weekly visits. Her foster parents believe she is becoming isolated and withdrawn.

Plan:
1. Will continue to visit Sarah as inpatient and in clinic to assess symptoms of depression
2. No pharmacological treatment recommended at this time, pending further evaluation
3. Social work and DCF colleagues are coordinating visitation while she remains in the hospital
4. Patient and family has our contact information, and we are available at any time to help them or any team members
3. Sample Progress Note #2 (after more substantial contact)

Update:
Mark’s shortness of breath has worsened, and he now requires morphine in a dose that is sedating to keep him from experiencing air hunger. This has troubled his parents greatly, and his mother was reported to be frustrated and angry about his condition, “screaming” last night to the overnight nurse, according to his notes. They continue to fight in the room, and request that “everything be done” to help him, even though they previously, in a calmer state, agreed with Dr. P that there were no more reasonable treatments to offer him.

During our visit today, we were able to speak with his mother and father together, but Mark himself was responsive to verbal stimuli but noncommunicative. His mother cried during our visit, and his father did most of the talking. He was teary and sad too, each expressing moments of anger directed at the disease. They were apologetic about the previous night but forcefully committed to “doing everything” because, in their words, “we just want to feel like we were good parents.” They are angry about constant attention to “the CPR and not Mark’s cancer” and requested that no one ask about limiting interventions for at least a day or two.

Assessment:
Mark is an 8-year-old boy who was diagnosed in March 2010 with Hodgkin’s lymphoma and is now suffering from recurrent disease and a growing mediastinal mass that has not responded to chemotherapy nor to radiation. He has experienced many complications from his second round of treatment, including sepsis requiring pressors and later, typhlitis. We were originally consulted at the time of relapse to help his parents cope with their son’s poor prognosis. He is now dying and previous discussions of comfort care and limiting interventions have been outshadowed by their grief. They do show signs of acceptance and willingness to talk about his end-of-life care, though a period of support without a heavy conversation, focusing on his comfort and their emotional state, may best facilitate conversation given their current resistance to DNR orders and hospice.

Plan:
1. Will continue to offer daily support to family, along with medical, social work, religious ministries colleagues
2. Will follow up with family’s rabbi to invite him to participate in care here
3. Recommend revisiting the DNR conversation after two days in the context of a goals of care conversation, which we would be pleased to help facilitate
4. If Mark continues to suffer and team believes that he should not be subject to further invasive treatment such as intubation, or if his parents interfere with treatments needed to maintain his comfort, an ethics consultation should be requested by any team member
5. We are available to family or any providers at any time
Some further reading
(* are especially central to many issues on the rotation)

1. Narratives

2. Backgrounds on Pediatric H-O & Psycho-oncology

2. Decision-making authority, shared decision-making

3. End of life Care, Esp. for Kids
Mercurio MR (2010). The role of a pediatric ethics committee in the newborn intensive care unit. Journal of Perinatology 31: 1-9. [See case 2, “Katherine” which will introduce the use of the pediatric ethics committee and a hospital futility policy]

4. Stem Cell Transplantation
AAP Committee on Bioethics (2010). Policy Statement: Children as HSCT Donors

5. Research Ethics
* S. Joffe and C. Simon Case Study: Informed Consent from the Doctor? Hastings Center Rep
Appelbaum PS. Clarifying the ethics of clinical research: a path toward avoiding the therapeutic misconception. Am J Bioeth 2002;2:22-23