Bringing Psychiatry and Oncology Together Through Case-Based Learning

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Case-based learning is a well-established teaching method in medical education which promotes critical thinking and facilitates a real-world context that aligns with trainees' clinical experiences.[1] This method is particularly relevant in the field of psycho-oncology, which requires a holistic approach to patients, especially with children, adolescents, and young adults with unique developmental considerations. Individual providers are typically not experts in all areas of psycho-oncology, and therefore, effective practice requires a functioning multidisciplinary team where different perspectives and expertise can come together. This also allows for patient perspectives to be routinely solicited to ensure that treatment is coordinated and responsive to the patient needs.

In our general psychiatry program, nearly all residents in the program face the clinical task of supporting children, adolescents, and adults with oncologic diseases, as well as patients' families and other members of the clinical team, during the internal medicine rotation. Therefore, we sought to create an educational experience to provide exposure to psycho-oncology, an introduction to multidisciplinary team care, and to highlight the importance of the patient perspective. Case-based learning was utilized to provide an authentic scenario with challenges that were reflective of medicine in practice.

Method

Our target population was second year general psychiatry residents. The educational experience included a one-time 2-hour case conference integrated into a standing case conference that was part of their yearlong didactics. The conference consisted of a case discussion with input from both a child and adolescent psychiatrist and a pediatric oncologist, a discussion with an adolescent cancer survivor and the parent of a deceased patient, and a question and answer session. Post graduate second year psychiatry residents who were part of a large urban residency program at a prominent academic institution participated in the case conference as part of their formal second year didactics. The conference aimed to provide a framework to explore and understand the perspectives of the patient, treatment team and trainee. Additionally, we aimed to bridge the gaps in the appreciation of roles and experiences of the different disciplines involved in the care of these unique patients and to model effective collaboration.

The deidentified case was based on a patient who was under the care of both the psychiatrist and the pediatric oncologist. The case was presented in sections, creating uncertainty around the final outcome in order to best model the realities of the clinical process. Each section was followed by questions posed to the trainees which highlighted key transdisciplinary constructs. Specific topics included:

- What constitutes a 'terminal illness'?
- Approaching adolescent decision making and autonomy
- Mood symptoms in medically ill adolescents
- Navigating conflict between patient and parental preference
- Treatment refusal

Time was reserved for back-and-forth discussion both during the presentation and at the end of the session.

The presenters focused primarily on creating a safe environment within which challenging discussions could take place. They sought to demonstrate this with their own openness and modeling of vulnerability. For example, both the oncologist and the psychiatrist discussed their own experience of caring for the patient within the duration of the session. They were able to share their own reflections about meeting with the patient and their family over the course of treatment and how the relationship evolved. Both physicians were open about the disappointments of relapse, addressing patient anxiety, and boundaries with the patient and their family. The discussion included an emphasis on collaboration and communication particularly in the areas of breaking bad news and managing the patient and family's response in a developmentally appropriate manner. The child and adolescent psychiatrist worked closely with the oncologist to ensure that age appropriate ways in which the patient demonstrated their distress and anxiety was evaluated and separated from maladaptive responses. Conversations about end-of-life care, patient preferences, and directives were also discussed in the concluding part of the case. Modeling communication and collaboration while also acknowledging areas that could be improved provided a realistic view of what trainees could expect to encounter in practice. In addition, the values, beliefs and behaviors of the physicians were illustrated as they worked together. Development of positive and negative transference towards the patient, reflection on the physicians' own status as a parent, and ideas about attending the funeral of the patient were openly discussed with the trainees.

Results

The formal resident feedback for the case conference was collected anonymously through the electronic feedback software standardly used by the program as it is required for the assessment of the educational curriculum and for quality improvement. The comments were also qualitatively reviewed. Participants rated the usefulness, content, and applicability of the case conference using a Likert Scale. This data was collected standardly as part of quality improvement. The residents found the experience to be interesting and engaging as well as emotionally charged. Identified areas of improvement were to provide more focus on the delivery of bad news and to incorporate a forum for residents to discuss their own challenging cases. The residents described the case as very thought provoking. They found it helpful to think about adolescent and young adult development in the context of a life-threatening medical illness, and useful to address the challenges of forming a therapeutic alliance during their inpatient stay. They expressed appreciation of having the perspective of the oncologist on the case with personal experience providing care to this patient population. They also indicated that they found the display of collaboration between the psychiatrist and oncologist helpful and inspiring. Residents indicated that the case conference afforded both thoughtful insight as well as reassurance to trainees regarding this inevitable and painful experience that they would encounter during their careers as psychiatrists. Most of the residents reported that they "loved!" having the patient present and hearing about the patient perspective in a reflective manner.

Discussion

Psycho-oncology is a uniquely intersectional discipline and requires the provision of sophisticated clinical care that draws on knowledge of pediatric oncology, general pediatrics, psychiatric assessment and treatment, and individual and family-based psychological interventions. The case conference involving the incorporation of a unique and specialized psycho-oncology team demonstrates an educational experience that modern students of medicine expect and deserve. The case-based teaching and resultant discussion created a space where the collaborative relationship between psychiatry and oncology could be actively demonstrated.

Adult learning theory tenets such as building on prior knowledge and especially creating the environment within which learning can occur were the backbone of this approach.[2] The case-based model provided multiple opportunities for trainees to associate to their own clinical experiences and use questions to address areas of ambiguity or limitations in their own understanding. The flexibility of the case conference structure allowed trainees to guide the emphasis of the session. In our session, the focus became a rich discussion on the emotional responses to patient loss, the personal experience of the providers, and issues around resilience.

The inclusion of patient and family perspective enhanced the retention of the information by providing an evocative illustration of the real-life experiences of the individuals targeted by this intensive approach. A young adult patient and the parent of the deceased patient presented their first-hand experiences in their own words. The speakers brought to the forefront the experience of working with uncertainty, receiving bad news, and the experience of working with the treatment team. The trainees utilized the opportunity to ask more personal questions of the speakers to understand the unique challenges of this age group and what the patient and family found to be most helpful during the treatment while working with the 2 physicians. The parent responded to questions raised by the trainees in the areas of grief and bereavement and the family's appreciation of the timeliness of discussing the poor prognosis with the medical team. This experience allowed the trainees to learn directly from their patients and aided them in becoming better physicians.

In response to the feedback, future sessions would include additional space for trainees to bring their own cases and clinical challenges for discussion. Further, additional input and training on the delivery of bad news is indicated and could include the use of patient simulations or role-plays to build on the existing case-based learning approach.

Conclusion

As physicians become further specialized, and necessarily more collaborative, it is important to model to trainees how multidisciplinary care teams practice and interact in the real world. By incorporating the above principals and interventions, the participating practitioners were able to demonstrate that the use of a multidisciplinary and patient-centered case conference is an engaging and memorable approach that provided students with a meaningful educational experience.

Take Home Summary

We implemented a case-based approach involving the incorporation of a unique and specialized psycho-oncology team and drawing on a corresponding set of educational principles to demonstrate the kind of educational experience that modern students of medicine expect and deserve.

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