A day in the life of Tania Teolis, social worker

Social worker Tania Teolis is responsible for a 26-bed unit in the Department of Internal Medicine of the Royal Victoria Hospital of the McGill University Health Centre (RVH-MUHC). She sees patients aged 18 to 100 years of age with a variety of medical issues like pneumonia, cardiac problems, sepsis, alcohol or drug abuse, dementia and cancer. Her main role is to identify and respond to the emotional, psychosocial and environmental needs of patients and their families and friends following a diagnosis.

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Face to Face with... Helina Asumadu, patient attendant (PAB)

The flu is still around!

Tell me about your typical day on C-9.

You'll laugh. My shift starts at 7:30 a.m., but at times I'm here at 6 a.m. I come in early to find a parking space, then I come to the floor, relax and drink my coffee. Most days, I check on all my 12 patients even before my shift starts. I tell them I'll come back later to take care of you. On a typical day, I'll wash them, change their bed, give them breakfast. Some patients like to talk. I tell them: Let me finish my job, and I will come back and talk.

What do you talk about?

Their personal lives, their children, movies, music, whatever they want to talk about.

You seem to really like your job.

Of course, I do! For me, taking care of sick people is more than giving them medication. A shower and a clean bed, for example, can make patients feel better. Cleanliness is important to me, so I always make sure patients' rooms are spotless. I also tell jokes, dance and sing for them, I want to bring a smile to their faces.

I never forget the patient is somebody's mommy, somebody's daddy, somebody's son, somebody's daughter.

What's the secret to being a good PAB?

If you put yourself in your patients' shoes all the time, you will enjoy taking care of them.

Confessions...

Three things you can't live without: God, my children – Albert is training to become a doctor, Felicity works at the airport, and Kevin is in college – and my job.

Favourite hobby: Watching movies and cooking. I cook at least once a day, I don't like leftovers.

Favourite fitness activity: I exercise every day as soon as I get home from work! I have a small gym in the garage and I watch movies and dance videos while I work out. Once in a while, I take a long relaxing bath in my Jacuzzi afterwards.

Favourite place in Montreal: My home.

Favourite travel destination: I visit Ghana and Germany almost every year because I have family in those places, but this year, we're going to Cuba. I want to see how people live there.

Favourite quality in a person: I don't give up easily, so I like people who are perseverant.

Favourite place at the MUHC: My unit on C09. It's like my home.

Everybody has a story. We'd like to hear yours.
The therapeutic power of music

Music stimulates many areas of the brain and engages the body, mind and spirit. Who has never let themselves be carried away by a sweet melody, a playful rhythm or touching lyrics? We do appreciate music since immemorial times, but today, we also know how to use its benefits in care relationships within a structured environment. This is what our six music therapists do at the McGill University Health Centre (MUHC).

MUHC music therapists are a group of professionals who work with similar tools and goals, with patients living different experiences and struggles. They help their patients decrease isolation, anxiety and pain perception, express themselves and relax, improve their mood and morale, stimulate their memory and attention and develop coping strategies. They also support families and loved ones. In pediatrics, interventions such as improvisation, listening to or singing songs help them express difficult emotions around love and loss, or they may request music that takes them back to happier times, or that express hope and faith. Some patients are intimidated by the instruments, not—can benefit from music interventions, such as improvisation, listening to soothing music, playing percussion to ventilate difficult affects, or even singing despite aphasia that prevents them from communicating verbally. It’s a real gift to work with these patients.

Deborah Salmon: “In Palliative care, I try to discover what is meaningful to each patient, and use music to help them connect to their most authentic selves, to loved ones, or to their spirituality, and to promote a general sense of bien-être. Patients may choose to listen to or sing songs that help them express difficult emotions around love and loss, or they may request music that takes them back to happier times, or that express hope and faith. Some patients work on ‘legacy’ projects, recording messages, or composing songs and musical composition, patients learn new ways to express difficult emotions and cope with emotional and social changes, adapt to changes in physical appearance and explore existential questions. I evaluate the patient’s primary need and then propose one or two musical interventions, such as improvisation, listening to me play music, or a combination of the two. Some patients are intimidated by the instruments, but I know the tricks to bring them to touch them. Being creative helps patients express emotions that they cannot put into words, reconnect with themselves and distance themselves from difficult events.”

Kelly-Ann Van der Meer: “In cancer care, music therapy helps improve how the patients cope and adjust to their medical treatments. Musical interventions help reduce perception of pain and side-effects of chemo, reduce demoralization, better cope with emotional and social changes, and adapt to changes in physical appearance and explore existential questions. I evaluate the patient’s primary need and then propose one or two musical interventions, such as improvisation, listening to me play music, or a combination of the two. Some patients are intimidated by the instruments, but I know the tricks to bring them to touch them. Being creative helps patients express emotions that they cannot put into words, reconnect with themselves and distance themselves from difficult events.”

Christelle Jacquiot and Pascal Comeau: “We use music therapy to maintain or improve the quality of life of babies, children, adolescents and their families and promote adaptation to the illness and hospitalization. Music creates a more normal environment, stimulates all the senses and helps people cope with life challenges. In addition, musical activities facilitate interaction and communication and help in the overall development of children who are hospitalized for weeks. I feel privileged to contribute to comfort and growth of children hospitalized at the beginning of their lives, but also to support new parents in learning their role. It is a heart-warming gift to witness a smile!”

Pascal Comeau: “At the hospital, the children play with instruments, sing or write songs, choose music to listen to, and move and play to the sound of music. One way or another, they all enjoy it. For example, a baby can be soothed listening to sweet songs in his father’s arms, and a teenager can write lyrics and play instruments to express his feelings and to feel in control despite a sudden and serious illness. The aspect of my job that I like most is that I make a positive difference for these patients and their families with a medium that easily reaches children and that I love: music!”

Dany Bouchard: “In psychiatry, music therapy sessions are provided individually or in group settings to help reduce anxiety and feelings of isolation, maintain cognitive skills (attention, concentration, refocus on here and now), increase the capacity of feeling pleasure, and improve social skills and self-esteem. Through improvisation, interpretation of meaningful songs and musical composition, patients learn new ways to express difficult emotions and explore their creativity. I focus on doing what’s best for patients. In some cases, this can include listening to soothing music, playing percussion to ventilate difficult affects, or even writing lyrics and finding music that allows them to better manage their emotions. Sometimes we record songs that patients make up with me. What I like the most about my work is the creativity that it produces, as well as the relational and human aspect that grows and deepens with patients through the universal language of music.”

Joanie Ayotte: “My patients are residents of the Camille-Lefebvre Pavilion, where they receive long-term care. I offer individual music therapy sessions to patients with respiratory problems. Music acts as a stimulant to facilitate communication, while singing and conversation help improve lung capacity. I also facilitate group sessions where residents have the opportunity to move and socialize. By using songs that have special meaning for patients, we can bring out memories and thus help maintain cognitive abilities of older people. I find it fantastic to see the elderly awakening through music, reciting the words of a familiar song or singing despite aphasia that prevents them from communicating verbally. It’s a real gift to work with these patients.”

Joanie Ayotte: “My patients are residents of the Camille-Lefebvre Pavilion at Lachine Hospital.”

Pascal Comeau: “At the hospital, the children play with instruments, sing or write songs...”

Christelle Jacquiot and Pascal Comeau: “We use music therapy to maintain or improve the quality of life of babies...”

Dany Bouchard: “In psychiatry, music therapy sessions are provided individually or in group settings...”

Deborah Salmon: “In Palliative care, I try to discover what is meaningful to each patient...”

Kelly-Ann Van der Meer: “In cancer care, music therapy helps improve how the patients cope...”
I always thought a transplant was something in the future, but I never expected it to happen at that point in my life,” says Dan, who’s a video editor and host for a YouTube channel. “After I told my friends and family, we started figuring out who could be my donor. The process of evaluating a compatible live donor takes three to six months. Candidates must undergo a battery of tests and see several specialists. At first, Dan’s mother was selected as the most suitable donor, but at the last minute a kidney ultrasound revealed otherwise. The next candidate on the list was Dan’s younger sister, Katherine. After all the tests were done, she was a 100 per cent match.

“It’s hard to explain, but from the beginning I had this feeling it was going to be me,” says Katherine, who’s 25 years old. “Dan’s my hero, and I’m super close to him. In my heart and in my mind, I knew I wanted to help him.” Katherine plays the saxophone and is studying jazz at Concordia University. Even though live donation is performed by laparoscopic surgery, it’s still painful. “Of course, I was worried the surgery might affect my capacity to play my instrument, but I was more scared of not being able to give Dan my kidney than of going into the operating room.”

After a successful transplant, recovery was smooth. The transplant was performed on August 25 at the Royal Victoria Hospital of the MUHC. The kidney started working right away, and blood tests showed an immediate improvement in Daniel’s kidney function. At the hospital, he was under the care of a “fantastic and dedicated” nurse, Alejandro Ramirez.

“Alex was such a great spirit and walked with me, even when I didn’t feel like walking. He was stern but compassionate and wouldn’t let me get away with being just miserable. In spite of a few difficult moments, Daniel was soon discharged and within a month started to feel much better than before the operation.”

“Before my transplant I had to urinate every 45 minutes, even during the night, so for years my sleep was severely affected,” Daniel says. “After the operation, the quality of my life improved immediately. I would wake up feeling rested and had much more energy.”

Unexpectedly, the operation was much more challenging for Katherine. Recovering is usually easier for the donor, but she had major internal bleeding and needed two blood transfusions. “I was in severe pain, but the nurses at the hospital were amazing to me. If I had all the money in the world, I would buy each of them a new car and I would buy Debbie a house.”

“I used to worry about my future as a musician. But when something becomes a matter of life and death, all little doubts fizzle away. This experience made me be more of the person I want to be and it brought me back to the fundamentals of just how lucky we are to be alive and to live in a country where we have access to free quality medical care.”

The sibling’s relationship was also transformed. “The transplant definitely made us closer,” says Katherine.

From Dan’s perspective, he is incredibly thankful for the sacrifice his sister made for him. “I realize how insanely lucky I am to have a suitable donor who’s so close to me. Many people languish for a very long time on lists and on dialysis without finding a donor,” he says. “Katie was very brave.”

What’s love if it’s not meant to be shown?
What is life if it’s not meant be shared?” asks Katherine, who donated a kidney to her brother Daniel.
Continued from page 1 — A day in the life of Tania Teolis, social worker

7:45 a.m. It’s the start of a work day for Tania. She checks her phone and email messages, as well as the list of new admissions. Among her clients today are a 44-year-old woman suffering from alcohol withdrawal, a homeless man with pneumonia and a young mother who had a stroke a few months ago and now has anemia. Tania must assess the potential impact of their health issue on their family life, relationships, employment, financial situation and more and help them cope with their new reality.

9:00 a.m. Tania attends the multidisciplinary rounds, where a resident and/or attending physician, a physiotherapist, an occupational therapist, a dietitian, a liaison nurse, an assistant nurse manager and a social worker review work done on the previous day and discuss new cases. I never start my day with an agenda. It all depends on who comes in overnight or what is discussed in rounds with my colleagues. Nothing is textbook, and that’s the beauty of it.

9:30 a.m. While discussing with colleagues, Tania decides which cases she must attend to first. Most of her clients are elderly people; some patients have severe cognitive impairments, dementia or loss of autonomy and will no longer be able to return home; others have just received a diagnosis of severe illness. Each patient comes to the hospital with their own story. It’s important to support them and try to be culturally sensitive to their beliefs and values.

10:00 a.m. Tania’s first client is Mr. Schwartz, a feisty, independent 100-year-old man with significant cognitive impairments. The team believes his safety will be compromised if he returns home, so he will have to be relocated to a nursing home. Tania has talked to Mr. Schwartz’s nephew, who has a mandate to become his legal representative. She will complete a psychosocial report, liaise with a CLSC to initiate placement and homologate/activate the mandate. Mr. Schwartz has recently been made aware. Seventy-five per cent of my day is dedicated to direct patient care, and that includes speaking with family members, friends and neighbours who’re involved in their care. Most patients don’t live in isolation.

The redevelopment of the Lachine Hospital: a unique, exciting and creative experience

The Lachine Redevelopment Project was officially launched in March when 40 people came together for a full day brainstorm from the $71.5 million project announced by the Ministère de la santé et des services sociaux (MSSS) in September 2015.

“We rarely have an opportunity to brainstorm like this,” says Dr. Ewa Sidorowicz, associate director general of Medical Affairs and director of Professional Services. “This is the first in a series of workshops to design a care and work environment focussed on patients and staff.”

The day consisted of a series of creative exercises aimed at identifying the core values and beliefs of the Lachine Hospital to ensure that the architecture authentically reflected this. No fewer than 2,862 ideas were put forward and have been summarized. They will provide the guiding principles submitted for discussion to various stakeholders. These principles will be integrated into the functional plan that will guide the architects at the design stage.

Dealing with the distress caused by cancer

The MUHC is participating in a research project that aims to support cancer patients’ psychological wellbeing.

Six years ago, Julie Szasz was diagnosed with stage III breast cancer, which is considered a treatable cancer. “I was young, and they said ‘she’ll be fine’, so I thought, ‘I’ll be fine,’” she recalls. “But psychologically, things were not easy. I overlooked getting any psychosocial help because I didn’t believe — and nobody insisted — that this would be necessary for me.”

Although it’s well-known that distress seriously impacts cancer patients’ outcomes, including adherence to treatment and quality of life, psychosocial care has lagged behind other treatment advances. But a new three-year joint project between the Rosy Cancer Network (RCN) and Cancer Care Ontario (CCO), called Improving Patient Experience and Health Outcomes Collaborative, or iPEHOC, aims to change this reality. Julie, who was re-diagnosed with metastatic breast cancer three years ago, is one of four patient advisors for the project.

“The literature reports that 35 to 45 per cent of cancer patients experience sufficient emotional distress to warrant professional intervention,” explains Dr. Marc Hamel, project co-lead and clinical director of Psychosocial Oncology at the Montreal University Health Centre (MUHC). A lot of the distress can be managed by front-line staff, but about 15 per cent of patients need referral to a mental healthcare professional.”

The idea behind this initiative is that once we understand the patient’s experience through the screening and outcome measures, we will be able to target the symptoms and identify the right intervention in a timely manner, explains Dr. Zeev Rosberger, iPEHOC’s principal investigator and the director of the Louise Granovsky-Psychosocial Oncology Program at the Jewish General Hospital (JGH).

Patients will be offered a distress screening questionnaire, already in use in Ontario, at set intervals in their treatment journey using a tablet computer. The software will assess their responses and generate a summary that outlines needs and interventions on an ongoing basis. The summary will in turn be provided to both the health team and the patient.

At the MUHC, the screening will be tested at the Lung Clinic of the Cedars Cancer Centre. The same pilot will take place at St. Mary’s Hospital Centre and in select cancer clinics at the JGH. The study, financed by the Canadian Partnership against Cancer and the RCN, will also be implemented among Inuit, First Nations and Métis communities treated within the McGill RUIS (Réseau universitaire intégré de santé). iPEHOC is the first project of its kind in Quebec. “We want to standardize screening across Montreal, across the province, and across the country, so that every patient — whether they are seen in Montreal or elsewhere — can expect the same kind of assessment and screening,” says Dr. Hamel.

Julie stresses that this project is not just for research or just about statistics. “It’s about helping patients right now,” she says. “From the get-go, patients have to feel that if something doesn’t feel right, then someone is addressing that.”
April, Parkinson’s Awareness month: Progress in the diagnosis

Six years ago, at age 50, Eileen Cortina was diagnosed with Parkinson’s Disease. Her first thoughts after leaving her family doctor’s office were: “It is impossible. I am too young to get Parkinson’s Disease. I have a very healthy lifestyle, I exercise a lot and there is no history of Parkinson’s in my family. It has to be something else!”

At the time, Cortina was a very active woman working as a Sales Director in Montreal. But, one year before being diagnosed, she started noticing a few changes. “I started to feel very tired and my movements were much slower. I didn’t have the dexterity I had before and it was becoming harder to write,” she says.

Parkinson’s Disease (PD) is the second most common neurodegenerative disorder in the world after Alzheimer’s. An estimated 100,000 Canadians suffer from it. It is a neurological condition related to the death of specific brain cells, including cells that control movement, mood, sleep and cognition. The symptoms, which include tremors, slowness of movement, stiffness or rigidity, sleep disorders, loss of the sense of smell, depression, and cognitive dysfunction, can appear in people as young as their thirties, but more commonly appear after 60.

Although some drugs and clinical treatments can help control or minimize symptoms there is currently no cure. Since other diseases have similar features but require different treatments, making the right diagnosis is important for properly treating Parkinson’s. With medication, most people with this disease can live productive lives for many years after diagnosis.

“Since my diagnosis, I have tried different medications,” says Eileen. “You always have to balance the outcomes and the side effects. But I am pretty functional these days. I feel good and getting involved in awareness or fundraising initiatives gives purpose to being diagnosed with this disease. In this way I can help others with PD.”

Improving and accelerating Parkinson’s diagnosis

According to Dr. Ron Postuma, neurologist at the Montreal General Hospital of the McGill University Health Centre (MGH-MUHC), the rate of misdiagnosis for PD can be as high as 25 per cent. “Full diagnostic certainty is impossible during life because it closely resembles other neurological disorders,” explains Dr. Postuma, who has been working for 15 years on Parkinson’s. “On top of creating distress in patients, mistaken diagnosis also creates a challenge for researchers as the data collected in clinical studies can become compromised in their pool of subjects.”

Currently, diagnosis of Parkinson’s can only be established through an analysis of medical history and a neurological examination by a clinician with expertise in movement disorders – no objective test for the disease exists. However, a recent research led by an international group of experts, under the umbrella of the International Parkinson and Movement Disorder Society (MDS), may pave the way for improving diagnosis and advancing treatment of Parkinson’s.

“In light of the latest scientific insights and technological advances, we were able to establish a new list of criteria based on expert clinical diagnosis,” says Dr. Postuma, clinical-scientist from the Research Institute of the MUHC and from the Montreal Neurological Institute, who was co-chair of the MDS task force with Dr. Daniela Berg from Tubingen, Germany. “Our aim was to create a benchmark that will systematize the diagnostic process, make it reproducible across centres and enable a wider range of non PD-specialized clinicians to provide patients with an accurate diagnosis.”

For example, the sense of smell is commonly lost in PD patients but uncommonly lost in alternate diseases. Now, it is included in the diagnostic criteria as another way to help physicians make the diagnosis. The new criteria has ways to balance information by including negative features called ‘red flags’ that argue against a diagnosis of PD and positive features that argue for a PD diagnosis. Red flags rule out probable PD diagnosis only when they cannot be counterbalanced by supportive criteria.

The research team pushed their analysis further. They are also proposing a new stage classification of the disorder with the aim of focusing attention on the early stages of PD. The goal is to identify the features that signal the presence of the disease early on, even before patients may notice motor symptoms.

“Our hope is that, as research advances, our understanding of the mechanisms at play in the disorder will enable us to develop therapies and treatments that can be administered early in this process, eventually slowing or stopping the progression of PD altogether,” concludes Dr. Postuma.