The dana-farber cancer institute

Business

How did DIF come about? The Dana-Faber, as it is commonly known, was originally established as the Children's Cancer Research Foundation in 1947 by DRP. Sidney Barber, then a pathologist at Boson's Children's Hospital. In the sass's the only treatment for cancer were surgical removal of tumors and radiation therapy. Cancers that had metastasis's were regarded as Incurable. DRP. Barber's vision was that children's cancer, particularly systemic cancers such as leukemia, could be cured If researchers and clinicians worked as a team.

He envisioned the union of research laboratories and patient care. As David Nathan, CEO of the Dana- Faber since 1995, explained, " The problems of the patients would be brought up to the labs and ideas from the labs would go down to the patients. " The history of the Dana-Faber is intimately tied to history of its funding. Initial funding for the Children's Cancer Research Foundation came from the Variety Club of New England. In 1948, the Variety Club organized a radio broadcast from the bedside of a young patient with lymphoma known as " Jimmy" as he was visited by members of the Boston Braves baseball team.

The donations that oared in to buy Jimmy a TV set on which to watch Braves' games were the beginning of the subsequently became the official charity of the Boston Red Sox, Ted Williams and the Massachusetts Chiefs of Police Association.

In 1974, the institution's name was changed to the Sidney Faber Cancer Center to honor Its founder, and in 1983, the name was changed to the Dana-Faber Cancer Institute to acknowledge the major contributions made

over twenty years by the Charles A. Dana Foundation. The flirts Children’s Cancer Research Foundation facility, the Jimmy Fund building, was built in 1951 and housed research laboratories.

It was expanded in the sass to include outpatient services, mostly for children. According to DRP. Barber’s original vision, the organization was to consist of research laboratories and outpatient clinics, but not inpatient beds, Inpatient care was provided at Children’s Hospital.

However, as research and patient care grew to Include adult patients, the doctors at the Dana- Faber were faced with the problem of where to admit adult patients. In particular, the new technique of bone marrow transplant (BMW) required the patient services of a general hospital. A Joint program existed between the Dana-Faber and the

Homology Department at the Brigham and Women’s Hospital. However when the BAH would not permit Dana-Faber physicians to admit patients and retain control of their clinical care, the Dana-Faber decided to open Its own Inpatient service, Militantly for BMW patients in 1979, and later, for general oncology patients. In fact, the system for hospital reimbursement in effect since 1983 favored the opening of inpatient beds at the Dana-Faber.

General hospitals, such as the Brigham and Women’s, are reimbursed for all Medicare and many non-Medicare patients on a DRAG basis.

On the other hand, specialty hospitals, such as the Dana-Faber, were remitted to charge Medicare and other Insurer’s full costs. This revenue

allowed between 1985 and 1995. In 1995, the Dana-Barber had 57 licensed beds, 2, 088 inpatient admissions and 55, 427 outpatient visits. 2.

What was the hospital’s primary mission regarded as incurable. DRP. Barber’s vision was that children’s cancer, particularly systemic cancers such as leukemia, could be cured if researchers and clinicians down to the patients. ” 3. How did the mission evolve? 4.

Explain Phase I & II clinical research trials.

Phase I and II trails are designed to understand the effects of a drug in the human odd. They examine the toxicity and effectiveness of the drug and the way that the body metabolites the drug. Phase I trails require that blood samples be drawn as often as every few minutes for a period of several hours. Phase II trials are undertaken after a drug has been tested in a small group of people and the correct dosage has been established.

They examine the efficacy of the treatment in a larger sample of patients. Phase II trails compare this drug treatment to patients who are receiving conventional therapy.

All trails are implemented using a research protocol, lengthy and detailed document that describes the following: 1. The objectives of the research and its rationale 2. The details of the drugs to be administered (dosage, frequency and route of administration), including the way in which the correct dose is to be calculated for any individual patient 3. The treatment to be administered (either investigation or conventional) 4.

The criteria by which eligible patients are identified as potential candidates for the trail 5.

The method of randomly assigning patients to the intervention and control arms of the trail 6. The endpoints being measured 7. The way in which the wellbeing of patients will be monitored over time (type and frequency of labs tests). 5.

Explain how chemotherapy works. Cancers whose growth is restricted to a local area can be removed surgically. Those that are localized, such as malignancies of the blood and cancers that have already agents block essential process by which cells replicate, and therefore kills all replicating cells.

Because cells in the cancer are replicating at a greater rate than announcers cells, the cancerous cells are killed preferentially. But chemotherapeutic agents are also harmful to normal cells, especially those with Geiger rates of turnover, such as the cells lining the intestines and white blood cells, a component of the immune system.

Common side effects of chemotherapy include immune suppression, nausea and hair loss. The extent of these side effects is related to the dose of the drugs. Less common toxicities related to these drugs include heart and ling dysfunction.

Chemotherapy is usually delivered in courses, each lasting several days, every few weeks. The time off the drugs allows normal tissues time to

recover. White blood cells numbers decrease after each course of chemotherapy and recover in the intervening days.

Each course is preceded by blood test to check that the white blood cell numbers are back up to the normal range, and that heart, liver, and kidney function are not disturbed. The dose of chemotherapy s calculated based in the body surface area of the patient (milliards per meter squared), which is calculated from the patient's height and weight.

Patients are weighed prior to each course of therapy. Doses of chemotherapy can be expressed by either daily of courses doses. The course doses are the sum of the daily doses.

Because of the will known side effects of the chemotherapy, patients are even additional medications, such as anti- nausea drugs. 6. What is the process that the nurse goes through when a new patient arrives? Upon arriving at an inpatient unit, a patient met his primary nurse and was formally admitted to the unit. Each new patient was assigned a primary nurse and two or three associate nurses.

The primary nurse was the patient's first point of contact with this unit.

The associate nurses cared for the patient when the primary nurse was off duty. The first thing that the primary nurse did, prior to administering chemotherapy, was to check the patient's consent form. The original was kept in the tangent's medical record, and a copy was kept in the protocol binder in the physician's dictation room. Next, the nurse determined whether or not the patient was being treated under a research protocol.

The only way she could do that was to look at the physician orders that the patient often carried with him when he arrived on the unit. Medication order was also often written after the patient arrived on the unit.

The nurse manager information or research protocols unless previously notified by the oncology fellow. If the research protocol was not with the physician’s orders in the patient’s record, he admitting nurse looked for a copy in the files on the unit or went to the Protocol Office. For common protocols, nurses frequently carried index cards listing the details of the treatment.

If the protocol was new the nurse might have to look up additional information on the purpose and design of the protocol. Finally, in admitting a new patient, the nurse measured the patient’s height and weight, and calculated the body surface area.

With this she verified the calculations of the looking in the hospital formula, other standard references, or the research protocol. Before beginning any therapy the nurse checked the results of the blood test that the patient had when he arrived at the Dana-Faber.

When the nurse received the bag of the chemotherapeutic agent from the pharmacy she cross checked the label on the bag with the drug order sheet in the patient’s drug book. Having confirmed that the drug and dose written on the label of the bag matched the order in the drug book and that the patient’s name on the drug sheet and bag matched the name on the patient’s identification arm band, the nurse began infusing the solution of

chemotherapy. The duration of the chemotherapy often spanned several nursing shifts.

Each nurse coming on duty went through the same confirmation process Just described.

She checked the patient name, drug and dose on the label of the bag, the drug order book, and the patient’s consent form, and recalculated the dosage, but she did not necessarily check the original drug order. 7. What kinds of safeguards are present in the process of administering chemotherapy to patients? Chemotherapy is usually delivered in courses, each lasting several days, every few weeks. The time off the drugs allows normal tissues mime to recover.

White blood cells numbers decrease after each after each course of 8. Explain occurrence screens.

Quality assurance (SQ) activities were similar to many hospitals nationwide, largely because they are mandated by state agencies such as the Board of Registration in Medicine and the Commonwealth of Massachusetts Department of Public Health, as well as the COACH. Each department undertook quality monitoring and improvement activities. For clinical care, quality assurance information was collected in several ways. After discharge, medical records were reviewed manually by a medical gynecologist who was Jointly employed by the SQ and Infections Control departments.

She screened the record for evidence of any one of 20 adverse events, such as death, re-admission, pneumonia secondary to an invasive procedure, and

central lines improperly placed. These events were called “ occurrence screens. ” In addition, adverse events were monitored through an “ incident reporting” system. There was an unexpected incident or negative outcome, such as a patient fall or a medication error. Some incidents were reported by phone call.

The supervisor of the area concerned had to complete a few questions about the response to the incident, sign the form and pass it on to the SQ department.

As Karen Nelson, Director of the SQ department said “ 99% of these said ‘ nurse was counseled’. ” 9. What were some of the issues noted in the case study that might have led to this incident? She was admitted to the Dana-Faber for her third round of high dose chemotherapy on November 14th, 1994. Her treatment involved a bone marrow transplant.

The purpose of high dose chemotherapy is to kill tumor cells, but it also kills healthy bone marrow. Therefore, healthy bone marrow was removed and held in reserve prior to high dose chemotherapy and then re-injected after the homoeopathy.

The treatment used was a very high dose of a common chemotherapy agent, kaleidoscopically. The dose was so high that normal bone marrow would be killed. In addition to the common side effects of hair loss and gastrointestinal upset, high dose kaleidoscopically was known to be toxic to the heart. Lehman was participating in a clinical trail and so, in addition, received the anti- ulcer drug conditioned, which had been shown in animal studies to boost the effect of kaleidoscopically.

10. If you were DRP. Sullen, how would you have addressed this incident initially and then ultimately?