

MD Anderson Cancer Center Japanese Medical Exchange Program  
JME Program 2018 Report

Aug 30, 2018 ~ Oct 6, 2018.

Kyoto Second Red Cross Hospital  
Outpatient Chemotherapy Center

Kota Asano

## Mission and Vision

### ●Mission:

(日本語)

化学療法を受ける患者に栄養や食事に関するに質の高いケアの提供を行い、食べることの喜びを見つけること。看護師が最新のEBMの知識を蓄積することを保証することで、看護介入による、より良い患者アウトカムを持つこと。

(英語)

To provide chemotherapy patients with the highest quality of care regarding nutrition and meal and finding joy of eating. By ensuring nurses are equipped with the knowledge of the latest evidence-based practice. And patients have better patient outcomes because of these nursing interventions.

### ●Vision:

(日本語)

全ての化学療法を受ける患者が、味覚障害や食欲不振を軽減するケアを受けながらも QOL を大切にして、栄養や食べる喜びをどのように楽しむかをサポートすること

(英語)

To support every chemotherapy patient on how to enjoy their quality of life most importantly, their nutrition and joy of eating even while taking care to reduce taste disorder and loss of appetite.

<b>I Purpose/Method</b>	<b>Page. <u>1</u></b>
<b>Purpose</b>	
I actually observe the Team Oncology held at MD Anderson Cancer Center and learn the role and ideal of doctors, nurses and pharmacists in team medicine.	
<b>Method</b>	
<ul style="list-style-type: none"><li>● In training at MDACC, I observe the roles and cooperative ways of multidisciplinary teams in wards and outpatients.</li><li>● I study about the skills necessary for team medicine by rethinking the ideal way of self through leadership training.</li><li>● I consider your career through training on career development.</li><li>● I collaborate with multidisciplinary team (doctors, nurses, pharmacists) and create oncology programs making full use of their expertise.</li></ul>	
Schedule: August 30, 2018 - October 6, 2018	
JME participants: 3 doctors, 2 nurses, 2 pharmacists	
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1. About MD Anderson Cancer Center

The MD Anderson Cancer Center (MDACC) I visited is an institution located in a corner of Texas Medical Center in Houston, Texas. MDACC in the cancer department of the hospital ranking conducted by the US. News & World Report is chosen as the best hospital every year, and it is the cancer center representing the United States.

According to Quick Facts 2018 issued by MDACC, the number of patients in 2017 was 137,000 (44,000 of whom were new patients), the number of outpatients undergoing surgery and treatment was quite large, 1,441,403. But the number of beds was 681 beds and it was surprisingly small impression given the outpatients hospital size. MDACC not only shortened the hospital stay but also was able to recognize again that many visiting hospital patients attended hospital for examination and treatment. There was a hotel in the building next to the hospital. The patient can take blood exam at the hotel.

In addition, the number of staffs was 19,530, not only the staff but many staff members of the staff were supporting the facilities, and 1,141 volunteer staff were enrolled, and it was found that many stakeholders are supporting it. MDACC was a huge hospital in terms of facility size as it had a huge campus that span multiple buildings so that it had to move between buildings using a shuttle or bus.

2. The places and contents of training at this MDACC

- Learn about multidisciplinary teams and team medicine (Dr. Ueno Meeting)

Inpatient Round: Multidisciplinary Rounds in wards: Shadowing of Multidisciplinary team of NP (Nurse Practitioner), Clinical Pharmacy

Clinic Round: Breast Clinic, Breast Surgical Oncology Clinic: MD, NP, RN, Clinical Pharmacy

- Learn about nursing in medical care team

Nursing Round (shadowing of RN in transplant wards and palliative care wards)

Clinical Nurse Leader (CNL) rounds: CNL shadowing

Shadowing of outpatient NP and nurse

Lecture on nursing management

Nursing Ethics Rounds

- Learn MDA and American cancer care

Mays ATC, Breast Surgical Oncology, Radiation Oncology, Infusion therapy, WOC Nurse round, Houston Hospice Tour, Breast Survivorship.

- Meeting

Pathology Meeting, IBC Clinical Consensus Meeting,

- Lecture

Dr. Ueno Meeting, Leadership development, Ethics

- Others

3. Patient Education, Service Excellence Modules, GU clinic, Antimicrobial Stewardship Discussion, Attending Conference: 22nd Annual Interdisciplinary Conference on Supportive Care, Hospice and Palliative Medicine,

**1. 1. About Team Oncology and Mid-level Provider**

In MDACC, team oncology surrounding cancer patients was high performed, taking advantage of each occupational characteristic of multiple occupations. In addition to doctors, occupations such as Nurse Practitioner (NP), Physician Assistant (PA), Clinical Pharmacist and so on it was called Mid-level Provider (Practitioner) demonstrate professional abilities in team medical care. I learned that I was contributing to improving the quality of team medical care.

**2. Team Oncology at outpatient**

I will talk about medical treatment in Team Oncology at MDACC outpatient. In this training, we got the opportunity to accompany the doctors of breast medical oncology / breast surgery, APN, RN, clinical pharmacist. Many professionals worked together as a team, it turned out to be a support as a team surrounding one patient.

Looking back on the actual outpatient scene, at first, the patient was called from the waiting room. Nurse assistant takes vital signs and enters the outpatient private room (Exam Room). In Japan, patients are called and entered into one exam room, so it was very surprised by this method that method. In the general exam room of a Japanese institutions, we can also see the state of a neighboring exam room through the curtain. Therefore, patient privacy can't be protected in a problem. In the case of MDACC, because the exam room is in a private room, the privacy of the patient is protected, and I realized that the patient was able to talk about my own feeling with confidence.

After that, Registered Nurse (RN) assessed the symptoms such as the pain, the side effect of drug therapy, and the condition of the wound site after surgery using template in the electronic medical record by EPIC system. Physical symptoms, mental symptoms, social aspects were also able to do a unified assessment using the template tool. They also checked for the presence or absence of oral medicine. By triaging not only physical symptoms but also whole human assessment of RN, RN has led to effective cooperation of other occupations afterwards. They assessed the risk of falls at the time of outpatient as well, and it also helped them to prevent the risk of falls and I was quite surprised by the high awareness of the quality of nursing.

By making a symptom assessment as a template, any nurse was able to observe at a certain level. Focusing the problem by doing a triage before a doctor's examinations, they were connected to a highly satisfying outpatient by consulting with NP and Dr. afterwards.

In one the observation matter of RN, it was different from Japan that they checked the situation of oral medicine one by one.

Confirming the state of use of medicine and assessing it is important not only that the treatment takes full advantage of the effect, but also it leads to compliance problems of oral medicine and leads to self-care support.

Once the patient's consultation is over, the RN returns to the Work Room, communicates with the NP about the observation and assessment, focuses the problem on what is happening to the patient.

As a role of outpatient NP, it was that we were able to order medical examination and image examination from the result of doing the examination and doing the assessment by themselves, to be connected to diagnosis and to prescribe.

Questions from patients and families also thought that NP carefully responded, so that the patient may have a feeling that they are being listened to more than Japan.

In addition, they entrusted doctor's routine tasks such as inputting an explanation of the results of the image inspection and an examination result report of the image examination into the medical record. After that, NP communicated with Doctor, discussing problems occurring in the patient, and doing doctor's work such as adding necessary order.

In the examination of Physician, they supported patient-oriented treatment decisions based on objective data on doubts about treatment and disease. Even at the examination of all Dr. I visited, they caught the relationship with the patient, talked with each other both in mind and body, and saw a scene politely answering each question.

According to Professor Ueno, in the medical field of the United States, I heard that doctors are not good acts for PCs without looking at patients.

I also felt that Physician were supporting the patient-oriented medical care such as answering questions until patients were convinced while face to patient seriously in the examination place. In order to truly realize the medical treatment that the patient wishes, medical doctors promoted that patients participate their therapy actively. in other hands, I also strongly felt the difference with the Japanese culture of "I obey doctor's choice, and I will leave up to you all." In addition, I were able to see a scene that physician shake hands and hugs to empower patients who have worked hard and sometimes hard treatments with patients and their families, and I was very impressed MDACC physicians was truly heartfelt.

Also, a clinical pharmacist came to a doctor for getting a patient's information and was actually asking how much the cancer stage was. In the record of the pharmacist there was also "Goal" and "Assessment" items. I can reaffirm that outpatient pharmacists were also involved in decision making patients treatment.

In this way, I understood the meaning of multidisciplinary team is that by listening to a lot of voices from patients, it is possible to realize highly individualized medical treatment with high patient satisfaction and to prevent overlooking symptoms and risks beforehand. I thought that they could provide high quality medical care. It also realized that the doctor's work is make an efficient system that brings out the professional part of each occupation to the utmost, such as consolidating in the decision of treatment. Looking back on the scene of examination in Japan, patients wanted to tell a lot of things about disease and treatment at short period of time, it is easy to conflict, but patients have increased the negative emotions for doctors, I thought that the satisfaction level might not rise.

### 3. Team oncology at the ward

I was able to visit the blood internal medicine ward this time. In the ward, I accompanied RN, CNL shadowing and NP, pharmacist team rounds. RN's role is similar of a nurse in Japan. Medical treatment around patient bed (i.e. when visiting a patient, while taking care of medical treatment, care

assistance after dining, pain Including symptom management, including taking care of oral medicine) and indirect medical care such as administration of infusions. In the morning, they shared patient information with Clinical Leader Nurse (CNL) belonging to the ward and confirmed the direction of nursing, followed by patrolling the patient in charge. I also participated in the patient conference that was held in the morning. Social workers (SW), RN, CNL, Physical Therapist (PT) gathered together to hold a patient condition conference, discussing patient care and goals in multiple occupations. It was impressive here that active communication was taking place in many professions.

The number of patients in charge of RN 1 person was about 3-5 people. When a multidisciplinary team including his / her doctor came to the ward, they were communicating by notifying the state of the patient at the conference and receiving instructions. Like outpatient department, they observed patients' symptoms according to the assessment items described in the EPIC system. The EPIC system also uses a method like to do list, for example, there are work as list like "get a consent form". I thought that it was efficient to be able to complete the work, if nurse may check all of list. In the template, it was a template using various scales, so that any nurse could do observation uniformly. Skin checks and assessments of falls that are related to quality assessment of nursing have also been worked every time. In the case of skin check, they performed an evaluation like a simple Braden scale and they also entered an assessment of fall risk. There is a large white board written in the patient's room called "Two-way communication board", and the daily goal is set in collaboration with the patient as the Daily Plan of Care Goal, and in Information / Question for My Care Team. Patients could fill in if there was a question from the patient. They always can see the goal of pain was written, and know the name of the responsible doctor, charge RN, charge CNL as information of Care Team. In addition to RN, it is also here that medical personnel communicate with patients, practicing patient-centered medicine. In Japan, there is a case of planning a nursing plan in collaboration with a patient, but it is somewhat ineffective and there are scenes where it is only documents, so a board became very helpful. Every day, while watching the board, patients realized that it is a patient-oriented plan and medical treatment in a true sense that medical doctors will communicate their goals while communicating. When I saw St. Luke hospital adjacent to Woodlands at MD Anderson Cancer Center, there was a communication board as well.

The patient's goal of Communication Board is that many are described as "Please Call, do not Fall". The patient must also be aware that they share the risk of fall and that they are careful not to fall down carefully I heard that I got it. On the wall of the patient's room is a board written "Movement is medicine".

1. Get up to eat.
- 2.Exercise.
3. Groom yourself.
- 4.Use a spirometer (to use a spirometer)

They intended to urge the four goals to work as role of patients. These are nurses in the evaluation of the quality, it is directly connected with items such as falls, prevention of pressure ulcers, pneumonia prevention, etc. It was a little impressed by the appearance of working with patients and nurse toward same goal. Fall and occurrence of pressure ulcers are the evaluation items of nursing quality

evaluation program in the United States, NDNQI is one of the requirements of the Magnet Recognition Program, and the Magnet Recognition Program is also a requirement of Hospital Ranking of US news. In order to connect, it was found that all the efforts at the work site are connected to the evaluation of the hospital all. In the ward, it was very impressive that Clinical Nurse Leader (CNL) was demonstrating leadership, considering the care direction of patients in wards. Although CNL graduates from graduate school, it is not an advanced practical nurse like NP. It is said that it is a generalist educated leadership who can evaluate the quality. Since CNL is not certified in Japan, I did not know what she was actually doing. But I understood it a bit by actually seeing the work.

As CNL's work, they had a presentation of the patient in charge of myself at a multidisciplinary conference in the morning, and active communication was done between many professional. In the patient list used for the conference, patient risks such as CAUTI and Fall were written, which was also shared in many professional. As items evaluated by CNL, data such as pressure ulcer, fall risk, nurse satisfaction degree, re-hospitalization rate, etc. were used as data to improve the quality of on-site nursing. Moreover, these data are posted on the ward as "Creating a Culture of High Reliability in Patient Safety" and "Creating a Culture of High Reliability in Patient Experience", and patients and families can also see the evaluation of the quality of ward nursing.

CNL was also paying considerable attention to Fall in front of the patient. An elderly female patient was hospitalized, but she was supposed to ring a sensor call when she left the bed. I met a scene where drinking water is overflowing in my room. In the case of Japan, it is a scene to call a cleaning company to wipe the floor, but CNL in MDACC was wiping the floor instantaneously to prevent fall risk.

I also saw a scene where CNL actually guides patients before discharge.

There are the items of discharge patient education were many items than in Japan.

CNL saw that it had been advanced while confirming the understanding of the patient one by one, the use of resources such as images, the confirmation of medical institutions to consult after discharge, etc. I envied that such a CNL would be in the ward as a leader in Japan.

#### 4. About APN (Advanced Practice Nurse)

I was very interested in the role of advanced practice nurses in actual situations and how they are contributing to quality improvement efforts. Professor Ueno said, once in MDACC, it was short of medical doctor. Therefore, the circumstances that I decided to adopt Mid-Level medical providers such as NP, PA, Clinical Pharmacist. I thought that it is meaningful that there is such a history of MDACC and that it has reached the present system.

The differences from Nurse Practitioner and Physician Assistant are described below.

Nurse Practitioner (NP): After obtaining RN, she undergoes clinical training at the nursing graduate school for 2 years, acquires her master's degree, and is certified after obtaining the qualification exam. 5 years renewal required (no exam required) Prescription rights and opening right. Under the supervision of a doctor, they can conduct medical practice.

Physician Assistant (PA): After graduating from university, receive a two-year training at Medical

School and obtain a master's degree. Under the supervision of a doctor, they can do medical care. Since PA is trained in Medical School, it is rather superior to examination skill compared to NP. On the other hand, NP has a point of view of nursing, such as do patient education rather than NP, and if we look at each master's degree acquisition course, we can see a feature.

In this time, I got the opportunity to follow NP several times and actually encountered a scene to order medicine and examination after the conference.

The biggest difference with APN in Japan is that depending on the state law, it is that legal discretion such as diagnosis and prescription can be done, and opening NP is recognized. In Japan, there is CNS (Certified Nurse Specialist) which has finished master's degree and CN (Certified Nurse) which can be obtained after the 6-month training finish, but it is the nursing association recognition system. It is different from NP like the United States Since there is no discretion in the legal part, real is the same job scope as RN. Therefore, from other professional, it is difficult to see at a glance what kind of things Japanese CNS can be done, and it is difficult to judge the usefulness in medical team.

In fact, when asking Theresa who is a mentor, the MDA said that the Doctorate in Nursing Practice (DNP) and Middle-Level nurse is more needed. The reason was that it was necessary to raise the level of research and clinical practice. In Japan, I hear that there are still many institutions that do not agree with the manager. We have to think that APN need to contribute not only the quality of care, but also whether they can participate in common with the medical outcomes a little more and outcomes of medical team.

#### 5. Radiotherapy room

The MDACC had radiation such as IMRT and SBRT and proton (proton therapy) center. This time, I visited a radiation therapy room with seven treatment machines. In 7 radiation therapy rooms, IMRT and SBRT etc. were done. I was able to see the actual scene of treatment of SBRT (therapeutic instrument made by Varian). In the radiation therapy room, radiological technicians and medical physicists entered the patient into the treatment room and had them lie down on the treatment table, preparing fixtures and bath towels. Medical physicists and radiological technicians checked the dose, and finally, a radiologist check and start to treatment.

I can also saw regular examination at radiation therapy room. The outpatient examination method was multidisciplinary team like another clinic. First of all, RN do triage, and NP do examination, finally radiologists examined. Like other outpatients, each professional share the information, and communicating between professional, after carefully examining the patient. I can saw the occasion of accompanying the patient's doctor's follow-up after treatment. The patient asked the radiologist, "Where are the cells dead from radiation?", but she carefully answered the patient's question. By the way, there was a ring in the radiation therapy room. when all the treatments were finished, I felt a culture that values the empowerment of patients by ringing the bells in the radiation therapy room.

#### 6. Outpatient chemotherapy

I was able to visit Mays Clinic's dispensing tour and the 10th floor Infusion center this time. The basis of chemotherapy at MDACC is based on the principle that outpatient treatment can be done

outpatient as possible as. For that reason, there were also 5 treatment rooms in MDACC.

In all treatment centers, there are a private room, and in private room were equipped with a syringe pump, a monitor, a television, a suction pump, and oxygen. For the patient, it was comfortable and relaxed environment to receive treatment. Because it was large than the space of the chemotherapy center in a general hospital in Japan, there was no pressure feeling.

When treatment began, the nurse was visiting for an infusion. When the nurse asked the patient the name and ID number, the patient could answer properly. I was surprised that he was able to answer ID number. I asked him why he remembered to the patient, he answered "That's natural, because of receiving treatment". I thought that the high awareness of patients' subjective treatment also led to the fact that they remembered names about ID and their treatments. There was a patient who talked to me when I visited. He said that he came from China. Even if it costs more than the medical environment in his country, he wanted to get better treatment, so he came to MDACC only for treatment. For patients coming from all over the world like him, I realized that there is a great deal of expectation for MDACC. Patient guidance was not only RN but also NP was doing patient education. NP further shared information with his physician and Clinical Pharmacist.

Anticancer drugs were confirmed by iPhone, and after RN checked by double check, it was connected and administered. The exposure measures such as gowns, masks, double gloves, etc. were properly used.

On another day, I was able to visit the dispensing department of Mays. There, instead of a pharmacist, an occupation called a technician carried out intravenous drip co-infusion. The pharmacist checked the stuffed contents and worked was checking the regimen. When entering the mixing room, as a countermeasure against exposure, the hat, the foot cover and the glove were needed. I felt that the countermeasures against exposure of dispensing were stricter than in Japan. I am surprised at the pharmacist's job that its managed IP pump, pump was for hospital use and for 5 FU at home.

## 7. Career development

We were able to hear Dr. Ueno talked about the career weekly. I got concrete advice on Mission and Vision. Vision was the ideal world image, it is not a goal at all. Mission and Vision learned that people can remember them, that what they can say is important. And I should choose jobs based on Vision. In Mission and vision, I studied that the unique part is very important.

And I was able to learn about mentors and mentees which are important for career development. As a mentor, it is important for me to be involved in the mentee with the desire to success it somehow. It is also important to communicate with your mentor and to be a good mentee. I learned about involvement playing a role as a mentee.

I also learned how to write CV (Curriculum Vitae). I learned that CV is not just a resume, but a way of writing, and that I can appeal to myself. In Personal Statement, I also learned to include Mission & Vision and fill in what kind of activity you are working with. In Japan, I did not have the opportunity to write, so I was instructed to update every day, so it was a great learning experience.

## 8. Leadership

We got a lecture about leadership in Professor Janis' s and Professor Ueno. Such leadership training itself is not so much in Japan, so it was a very valuable opportunity to participate in this time.

Janis said, "Leadership is a Learner", and I learned that it is skill and ability to be practiced by anyone. Also, the leader is not individual status, individual attitude, and we learned that learning makes it more refined. She also taught us that We can improve more productivity by training excellent leaders. An ideal leader is not be a traditional dominant leader, and an ideal leader is supporting for the success of the members, working on the surroundings and creating a safe environment for the team, and finally will become the success of their team. An ideal leader is called servant leader. It is important that the leader is a good listener and keep learning a lot by reading.

There are also five important skills as leadership: 1) Model the way, 2) Inspire a shared vision, 3) Challenge the process, 4) I learned that Enable others to act, 5) Encourage the heart.

Looking back on what was actually done at MDACC, I think that "a shared vision" probably applies to scenes where communication is taking place with multidisciplinary team.

In Professor Ueno's lecture, Leadership has two kinds, Positional Leadership and Individual Leadership. Everyone can have leadership, should act on what is right and what I believe. I learned that it is important to act on my own Core Value and Mission & Vision and should not to be afraid of conflicts.

In Professor Janis' s lecture, I actually selected the Core Value from the list, learned about knowing my own Core Value, learning that it is important to know each other, and it is effective for understanding human relations and ourselves using Core Value. And Core Value is the basis of ourselves and it is useful when deciding priority.

Through Daniel Pink's report of a book named Drive, we learned there are three elements of learning how motivation is raised and motivating factors: Autonomy, Mastery, Purpose. In the environment, risk increases without psychological safety. For that, I tried to make psychological safety, and learned that it is important to discuss as much as possible.

## 9. Nursing management

I knew 2,450 nurses were involved in direct care in MDACC, 88% of which were found to be BSN, 3% to MSN, 7% to DNP. Magnet Recognized Program is a program that the American Nursing Association is conducting, it is a program to investigate hospitals where nurses are gathering and to investigate why they are gathering there. It is necessary to evaluate items such as quality of nursing, safety and community, MDACC has already got four times and planned to try re-certified next fiscal year. From the meaning that Magnet Recognized Program can only receive 5% of hospitals throughout the country, I also heard the high level of MDACC nursing quality.

I got an opportunity to learn a program for a new employee nurse. MDACC has accepted 300 newcomers every year and learned that there is educational program for newcomers. The newcomer orientation is divided into three parts, the first one to learn about MDACC, the way to use the computer, the general part to learn "code blue". The second one is Clinical Immersion, for example "what kind of patient in this unit." Third is learning as an oncology nurse resident such as chemotherapy, pain management and symptom management. There are about 30 education nurses in

the education department, so I am impressed about the fact that the person in charge is lecturing and that a program is tailored to the personal progress situation newcomer received it.

In the monthly program of newcomer nurses, newcomers learn techniques, projects and presentations. Specifically, it was to create a situation just like the real situation at the simulation center and simulate it so that newcomers can learn more closely to the clinical site.

For the Advanced Practice Nurse, fellowship of 12 months is also organized, and in the orientation period, APN has been using education such as rotating the place in 2-3 weeks, followed by submission documents for certification.

In the lecture on nursing delivery model, a small team nursing practice model was introduced mainly around CNL. The intervention of fall risk was also introduced. Patients with a high risk of falling should be wearing a yellow wrist band, wearing socks with anti-slip, and wearing a waist belt for transfer. Basically, because they value independence, they will never do body suppression. In Japan, it seems that I was quite surprised to tell her that body suppression is still being done. I also learned to bring social safety by doing Team discussion.

#### 10. Communication and systems between medical staff

I was surprised that the main interaction between medical staff was using E-mail instead of telephone. It was impressive to check large amounts of E-mails at the beginning of each job. Email has been trained so that the requirement is gathered in one line, and almost never talked on the phone for as long as in Japan.

As for this, since modern communication itself has been transformed into e-mail and SNS, it was told that there is such a trend in the medical world as a matter of course. Rather, I thought whether it is time to reconsider the telephone and long mails still in many Japanese medical facilities from the aspect of cost effectiveness. In interactions with patients, I was very surprised that there were inquiries by e-mail and a system that can access their own treatment results through the site called My MD anderson.

There was no patient explanation, agreement form and handwritten paper, and it was in electronic form. In the United States, I heard that the paper medium is considered dangerous because it is a source of mistakes and there is a fear of being forged. Regarding prescriptions, they are sent by fax or data from PC. The introduced letter of introduction is scanned and discarded immediately. Since I heard the news that the Japanese government is promoting for electronic documentation in the future, it became a great reference as a viewpoint that can be taken in medical care.

#### What I learned on Team Oncology

I was able to see the actuality of Team Oncology at inpatient and outpatient at this training. In Professor Ueno's lecture, we learned team medical care four elements:

1. Provide medical treatment with high satisfactions
2. Improvement of medical level
3. Improvement of patient's ability
4. Improvement of satisfaction of medical staff

I heard that if it can be achieved 4 elements, and it said that team medical care can be done for the first time. It was not just meaning that many professionals gathered and did team medicine. I think it is very meaningful that the outcome brought by Team Oncology is highly satisfied for patients and high as a medical level. In the future, as I am doing team medical care in Japan, I would like to suggest that the four points are very helpful points of view.

In order to realize team oncology, I also learned that learning Leadership, learning each one, and making opportunities to learn are necessary.

I thought that it is important to create “psychological safety” environment for team members and to actively communicate with the expertise.

I also thought about the environment surrounding the medical team. Higher position people learned that it is important to do more responsible work. Other jobs are carried out by subordinates. As a result, doctors can concentrate on doctor's work and can achieve a lot of results. And nurse can concentrate on nurse's work. If the same situation happens in Japan, I can probably imagine that a lot of staff will get exhausted. When I am thinking about why MDACC goes well, I thought how to delegate is important. It should be devised not to degrade the quality of work by creating protocols, digitizing and systemizing. F Nurses who put in PICC can use a special echo with an electrocardiogram to be able to put in superior cava vein surely. WOC nurse can use the photo function of the iPhone to immediately share information on the wound on the medical record with the doctor. The order of chemotherapy is double checked by the doctor through PC system. To be quality and safety can be secured even if it is not a doctor, there is to create a system formation and strategy to enhance reproducibility.

#### What I learned in improving the quality of cancer nursing

In MDACC, I think not only NP but also CNL 's role and work are contributing to raising the practical level of the site this time. In Japan as for NP and PA, I think that early realization is difficult, because there is legal maintenance problem. Therefore, in order to improve the quality of cancer nursing, I thought what I can do now. As a cancer leader nurse, I thought about developing general nurses. Professor Ueno was also pointed out, in Japan nurse have to change work wards when nurses have passed a certain number of years. Therefore, there is rarely a generalist like "She knows anything when asking here", and there are few soils where special nurses are likely to be born. In Japan, most every nurse believes that there is a tendency for organizations to be lazy to one another. If a nurse

become mid-level nurse, she will have to be transferred to the other ward. When I actually listening about the story of the transfer to several RNs in the MDA, "There is no change, as long as I do not desire" it was said. Since medical care are becoming more specialized, nurses as generalists who are more practical in each field become necessary. I thought that it is necessary to nurture such nurses and, as a result, to improve the quality of the primary team.

#### Creating an oncology program

This time, seven members of JME divided into two teams and thought about oncology program. I and Shu and Ryo were Team B. Considering the common terms of our members, everyone is engaged in medication therapy in some way, and also men. Women's care such as breast cancer is major, but is male patient care done? Therefore, we focused on how we can support sexual dysfunction in male patients.

Vision: A male cancer patient creates a society that lives like that person without suffering from sexual problems

Mission: Provide education and intervention programs to patients, partner medical staff, and reduce sexual problems of male cancer patients.

In this issue, we aimed to identify patients with sexual dysfunction in cancer patients, to use the assessment algorithm, to perform appropriate intervention programs and to intervene Men's Health Team.

Through this program creation, we had a discussion with three members like every evening. Throughout, I thought that it was the result of this time that three people were able to communicate towards the same Mission & Vision while accepting the difference in values by occupation, and the process could be shared.

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As my own future task, I think the first issue is how to spread the practice of Team Oncology in Japan. For that purpose, I think that it is not limited to my own facility but spreading opportunities such as lectures and writing. I also think that it is important to increase the number of J - TOP participants in Japan even at their own facilities, and to increase the number of friends.

For the realization of patient-centered medical care, it is considered that asking patients' opinions carefully.

For me to realize patient-centered medical care:

I carefully listen to the patient's voice.

I always empower patients while using opportunities such as patient education.

I support that you can make your own decisions by increasing the subjectivity of patients.

We will work on improving patient satisfaction as a team.

In addition, I will tell that patient-centered medical treatment is important from medical safety and economic ideas.

One of the words taught by Professor Janis was the word "Leader is skill and things to learn". I think that it is important to continue to study about leadership intentionally, such as reading a book on leadership recommended by Janis.

I felt at MDACC, that it is important for us who are medical staff to be approved by others. In the future Japan also thinks that the population of new-nurse nurses themselves will decrease and that the nature of the organization itself will have to change due to the aging of nurses themselves. I think that a mechanism to approve more self is also necessary. I felt the system like "Celebrate a Star" decorated in the ward of MDA was really nice. I would like to build a system that acknowledges our own efforts.

I would like to thank all the stakeholders involved in the JME 2018 program.

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