

Multidisciplinary Meetings in Oncology: The Need of The Day and The Future in Pakistan

Syed Aslam Shah, Sana Sharafat Ali

A Multi disciplinary team (MDT) is a selected group made up of various health professionals who work together to discuss suspected or newly proven cancer cases. Multidisciplinary care is the hallmark of high-quality cancer management.¹

Multidisciplinary meetings (MDM) are also known as tumour boards, multidisciplinary cancer conferences, multidisciplinary case reviews, or multidisciplinary clinics, in different health care systems. These different terms may represent the variations in the organizational structure, membership, approach, focus, and the decision processes of these meetings.² Quality cancer treatment depends upon careful coordination between multiple treatments and treatment providers, the exchange of technical information, and regular communication between all providers and physicians from various disciplines involved in treatment.³ These meetings provide a forum for multidisciplinary cancer teams to regularly convene and discuss the diagnostic and treatment aspects of patient care. It is a deliberate, regular, face-to-face (or videoconference) meeting involving a range of health professionals with expertise in the diagnosis and management of cancer.⁴ Over the last few years, regular multi-disciplinary meetings have become a standard practice in oncology and gained the status of the key decision-making forum for patient management. Multidisciplinary team meetings about a patient are a way to coordinate fragmented care.⁵

Multidisciplinary team is composed of Consultant Physician and/or Consultant Surgeon, Consultant Radiologists, Consultant Histopathologist, Consultant Oncologists and Multidisciplinary team Coordinator. Multidisciplinary team needs mature leadership to produce a democratic climate allowing for open and constructive discussion. As MDT's are a key component in a professional's routine, it is worthwhile spending

time considering the organizations, targets collaboration and documentation with MDT. The introduction of multidisciplinary meetings has improved communication between all members of the team. This has reduced delays for patients on the medical admissions unit to a minimum and produced a more appropriately structured inpatient stay.⁶ The degree of organization and the type of communication in these MDTs has a direct impact on the quality of patient care provided. One resulting decision from a multidisciplinary discussion is more accurate and effective than the sum of all individual opinions.⁷

The most appropriate treatment plan is that which optimizes survival and minimizes harm, at the same time having consideration for the maintenance of quality of life to provide educational opportunities for team members and trainees. The principal objectives of the MDM is to ensure, all patients with suspected or newly diagnosed malignancies are discussed by the multidisciplinary team, to determine in the light of all available information and with reference to the evidence base, the most appropriate treatment plan for each individual patient to record all outcomes and ensure they are implemented and to provide education to senior and junior medical, nursing and allied health staff.⁴

In order for MDT meetings to function effectively they require adequate information about the patient's disease as well as any physical or psychological co-morbid health issues.⁸ It is also recommended that information about the patient's concerns, preferences and social circumstances is presented at the meeting by someone who has met with the patient, such as a specialist oncology nurse or the treating physician.⁹ Shared decision-making between patients and their treatment team is considered to be best practice as well as the approach preferred by most patients.^{10,11}

Positive outcomes of MDM for patients include increased survival, increased perception by the patient that care is being managed by a team, greater likelihood of receiving care in accord with clinical practice guidelines, including psychosocial support and increased access to information, particularly about psychosocial and

Correspondence

Dr. Syed Aslam Shah
Department of General Surgery, Unit 1
Pakistan Institute of Medical Sciences
Islamabad.
E-mail: drsaslamshah@gmail.com

practical support. Evidence indicates that a team approach to cancer care can reduce mortality and improve quality of life for the patient.⁹

Benefits and incentives for clinicians to participate in MDM include patient care is more likely to be evidence-based, with implications both for clinical outcomes and cost-effectiveness. All treatment options can be considered, and treatment plans tailored for individual patients. Referral pathways are more likely to be streamlined. Clinicians have enhanced educational opportunities. Participants reported that MDMs have facilitated the incorporation of staff from traditionally diagnostic disciplines such as radiology and pathology into the treatment team, leading to closer working relationships. These closer relationships had a positive impact on other areas of clinical care outside the MDM.¹²

Ideally, an opportunity for a multidisciplinary team meeting will occur when diagnostic information is available or pre- and post-surgery (when surgery is the primary treatment). At a minimum, a multidisciplinary team meeting will occur prior to the commencement of neoadjuvant/adjuvant treatment. Following diagnosis, and prior to the commencement of any treatment, the patient should be informed that treatment planning by the multidisciplinary team is part of the normal process of care. The patient's consent must be sought prior to case presentation at the meeting and can be withdrawn at any time.

Participants reported that patients felt reassured by their case being discussed at MDMs but unanimously opposed patient attendance at the meeting.¹² The confidentiality of any information that identifies the patient should be respected.

In the United Kingdom, it is a mandatory requirement that the care of all breast cancer patients is managed through breast MDMs.¹³ These meetings help in consolidating oncological multidisciplinary working and allow transparent decision-making, standardization of care and recording of results.¹⁴ In an audit study, Burton et al compared preoperative MRI in consultation in MDT meeting to preoperative MRI without MDT consultation in rectal cancer patients. They reported that for the incidence of positive circumferential resection margin (CRM) was significantly higher in the group without MDT consultation (26% versus 1%).¹⁵ A team approach to cancer care can reduce mortality and improve quality of life for the patient.

It is only through the active engagement and incorporation of the views of all those involved in

cancer care decisions that MDMs will function most effectively, and in a manner that support the health professionals and also beneficial to the patients.

REFERENCES:

1. MultiDisciplinary Meetings for Cancer Care by Northern Cancer Network posted on 2 November 2011. Available from <http://www.hiirc.org.nz/person/3997/northern-cancer-network/>
2. Patkar V, Acosta D, Davidson T, Jones A, Fox J, Keshtgar M. cancer multidisciplinary team meetings: Evidence, challenges, and the role of clinical decision support technology. *Int J Breast Cancer* 2011.
3. Fennell ML, Das IP, Clauser S, Petrelli N, Salner A. The organization of multidisciplinary care teams: modeling internal and external influences on cancer care quality. *J National Cancer Institute Monographs* 2010; 40, 72–80.
4. Principles of best practice multidisciplinary team meeting. Multidisciplinary meeting toolkit. Available from: <http://www.docs.health.vic.gov.au/docs/docmeettoolkit>.
5. Houdt SV, Lepeleire JD, Driessche KV, Thijs G, Buntinx F. Multidisciplinary team meetings about a patient in primary care. *J Primary Care Community Health* 2011;2:272-6
6. Gallagher A. Multidisciplinary meetings in medical admissions units. *Nursing Times*.net 2004;100:34 Available from:<http://www.nursingtimes.net/.../Multidisciplinary-meetings-in-medical-admissions-units/201384.article>
7. Ruhstaller T, Roe H, Thurlimann B, Nicoll JJ. The multidisciplinary meeting: An indispensable aid to communication between different specialties. *Eur J Cancer* 2006; 42:2459-62.
8. Mileshkin L, Zalcborg J. The multidisciplinary management of patients with cancer. *Ann Oncol* 2006;17:1337-8.
9. Multidisciplinary meetings for cancer care. 2005. Available from <http://-canceraustralia>

Multidisciplinary Meetings

- nbocc.org.au/mdm-multidisciplinary-meetings-for-cancer-care.
10. Jefford M, Tattersall MH. Informing and involving cancer patients in their own care. *Lancet Oncol* 2002;3:629-37.
11. Brock DW. The ideal of shared decision making between physicians and patients. *Kennedy Inst Ethics J* 1991; 1: 28-47.
12. Devitt B, Phillip J, McLachlan SA, Team dynamics, decision making, and attitudes toward multidisciplinary cancer meetings: health professionals' perspectives, *J Oncol Practice* 2006, 6;17-20.
13. Patkar V, Acosta D, Naughton P, Jones A, Davidson T, Fox J, Keshtgar M. A versatile, evidence-based decision support system for breast cancer multidisciplinary meetings: results of an evaluation. Available from www.posters2view.com/sabcs09/viewp.php?nu=5118.
14. Rusby JE, Gough J, Harris PA, MacNeil FA. Oncoplastic multidisciplinary meetings: a necessity or luxury? *Ann Royal Coll Surg Eng* 2011,93.273-4.
15. Burton S, Brown G, Daniels IR, Norman AR, Mason B, Cunningham D. *Br J Cancer* 2006: 94:351-7.