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Current Perspective

The multidisciplinary meeting: An indispensable aid to communication between different specialities

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ABSTRACT

Multidisciplinary team meetings (MDT's) form part of the daily work in most hospitals caring for cancer patients as a form of institutionalised communication. The degree of organisation 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. Other benefits include consistency in the standard of patient management offered, a teaching element for junior doctors and improvement in communication between different specialists. An MDT needs mature leadership to produce a democratic climate allowing for open and constructive discussion. Controversies, which are inevitable within a team who are striving to reach decisions concerning complex situations, therefore require a variety of approaches for dealing with them when they occur. As MDT's are a key component in a professional's routine, it is worthwhile spending time considering the organisations, targets, documentation and collaboration within the MDT.

1. Introduction

In the last few years, the demand for multidisciplinary decision-making in oncology has increased markedly. Previously, a patient with locally advanced non-small cell lung cancer (NSCLC) would undergo surgery and possibly postoperative radiotherapy. Whereas today there is a need to discuss the different diagnostic measures required to determine the exact stage and treatment options, which can include surgery, radiotherapy, and chemotherapy in different combinations and sequences. The established way to deal with these complex issues is multidisciplinary meetings involving key specialists from the diagnostic and therapeutic modalities.

There is evidence that multidisciplinary care has the potential to significantly increase survival.[1,2] However, many other benefits are published, *i.e.* improving the health outcome of elderly inpatients after discharge,[3] increasing resection rate of lung cancers,[4] reducing medication variance,[5] offering better treatments, follow-up and outcome in hypertension.[6] In a US study, the initial treatment recommendation for women with breast cancer was changed following a second opinion of a multidisciplinary panel in 43% of the cases.[7] It is well acknowledged that the multidisciplinary decision-making process is able to greatly reduce the wide variations in decisions made by professionals acting independently.[8]

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In oncology there are some recommendations and guidelines for multidisciplinary team-working like in Australia or in the UK[9,10] but there is no universally accepted model of multidisciplinary care. Some cancer centres are offering multidisciplinary clinics where cancer patients can see specialists from various disciplines at one clinic. Another widely used option is to bring the different specialists together to discuss patients multidisciplinary care. These are mostly tumour-specific meetings and are known by different titles: multi-disciplinary meeting (MDM), multidisciplinary teams (MDT), tumour boards, cancer conferences, *etc.* We are using in this article the acronym 'MDT'.

These MDT's are part of everyday life in clinical settings regularly dealing with cancer patients. They often absorb several hours a week of many expensive specialists. A recently published study of breast cancer teams revealed that team composition, working methods and workloads are related to measures of effectiveness.[11] It is obvious that the degree of organisation and type of communication in these MDT's has direct impact on the quality of patient care. In this article, we are evaluating different aspects of organisation and communication of MDT's.

2. Different goals and benefits of MDT's

The primary goal of an MDT is to improve the care management for individual patients. The early implementation of the discussion process in the pathway of an individual patient can prevent unnecessary diagnostic investigations and save valuable time. One multidisciplinary discussion with all involved specialities is more effective and the joint decision more accurate than the sum of all individual opinions. Patients are treated according to the same guidelines and to the same standard regardless of whom the patient was initially referred to. Multidisciplinary discussed patients are more likely to be included in a clinical trial. MDT's allow for the necessary investigations to be incorporated in the diagnostic process and again prevent unnecessary or repeated investigations being performed. An MDT is also an ideal learning opportunity for junior doctors or other professionals. For a beneficial teaching environment, it is important to have a room with good acoustics, open discussion and, most importantly, clarity regarding how and why the final decision was reached.

Another important and often overlooked benefit of MDT's is the improvement in communication between different specialities. Cooperation and collaboration is greater when each discipline understands the roles, possibilities and limitations of the other ones, allowing a trusting relationship to be developed between specialities. However, not all goals match together very well. In particular, the efficacy of a meeting can suffer if the teaching aspect is to the fore. To declare the reasons for a decision takes time and specialists working together for a long time do not need many words to come to a decision. On the other hand, it can be sometimes quite challenging to have to justify a decision to a young, well-read colleague. Having involved specialists present and yet not wasting the time of members of particularly small diagnostic specialities with only very limited input to the decisions is a challenge for all MDT's. Overall, the many benefits offered by MDT's are obvious but these must be balanced against each other when determining the style and structure of a specific MDT.

3. Who should participate in an MDT?

Specific participation is dependant on the type of tumour being discussed, the goals of the MDT as outlined earlier and whether the meeting is to discuss diagnosis or treatment. We will focus here on an MDT meeting with a therapeutic intent.

In general, the three therapeutic modalities of surgery, radiotherapy and medical oncology form the core members of the team. Whatever the purpose of the meeting, it is beneficial to have representatives from the diagnostic specialties there, *i.e.* radiology, pathology, *etc.* Extended members of an MDT could be the invited GP of the patient, the clinical trials coordinator (CTO), a member of the palliative care team and/or a specialist nurse. The CTO will have knowledge of all suitable trials, along with inclusion criteria and is able to remind the core members of the necessary diagnostic investigations required. A specialist nurse may have a valuable contribution concerning the patient's individual and social environment better than the consultants. It is also beneficial to involve the palliative care team early in the treatment process. Often patients treated with palliative intention are not known to the palliative care team until late in the course of their disease.

Another important issue is the position of the participants. Importantly each representative must be able to make independent decisions. Another important factor is that all members have an equal voice in the meeting and require the ability to demonstrate real expertise in their field rather than be a specific grade. If there are several specialists from one treatment modality, it should be clear who the leader is and they must take responsibility for the final decision.

4. Workings of an MDT

4.1. *Announcement of an MDT*

Any specialty including the involved GP can bring cases for discussion at the MDT, and indeed, those outside the normal circle of the MDT should be particularly encouraged to bring all cancer cases to such meetings, since it is those cases which are diagnosed outside the 'normal pathway', which may benefit the most from being 'brought into the fold'. It is helpful if a coordinator is appointed to collect the cases together, write and disseminate the agenda. The agenda should be distributed before the meeting, so that all participants know beforehand which patients will be discussed, allowing for notes to be organised and reviewed, or uncommon issues to be reviewed before the meeting.

4.2. *How should cases be presented?*

This is certainly a key point of each MDT. All relevant patient information should be presented in the most efficient and concise way. Presentation can be verbal but should be backed up by projection on a screen. It does not matter too much as to who makes the presentation, as long as they are aware of