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Surgeons' views on multi-disciplinary breast meetings

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ARTICLE INFO

Article history:
Received 28 September 2005
Received in revised form
2 November 2005
Accepted 8 December 2005
Available online 3 March 2006

Keywords:
Interdisciplinary
Communication
Multidisciplinary
Interprofessional
Breast cancer

ABSTRACT

The aim of this study was to assess surgeons' views and their current commitments to multi-disciplinary breast meetings (MDMs). Two hundred and fifty questionnaires were sent out to registered members of the British Association of Surgical Oncology. Hundred and fifty-three were returned (reply rate 61.2%), of which 136 were suitable for analysis. All those who replied were involved in MDMs. 80.9% held MDMs once a week. Only 28% of MDMs were held during a protected session. Over 95% of surgeons and breast care nurses were present for the whole meeting. Radiologists and pathologists were present for the whole meeting in 90–95% of cases. In contrast, clinical oncologists were present for the whole MDM in 70% of cases and medical oncologists attended the whole meeting in only 44.1% of cases. There was variability in which patients were discussed in MDMs, and in many centres not all patients with cancer were discussed before surgery. Suggestions for improvement of MDMs included more time on protected sessions (72.8% in favour), time to prepare for meetings (29% in favour), allocation of a designated co-ordinator (30.9% in favour) and attendance of oncologists for the whole meeting (over 35% in favour). The majority of Breast MDMs were held at breakfast, lunch or the evening. There was variable attendance with a significant percentage of both clinical and medical oncologists not being present for the whole meeting. A quarter of units did not discuss patients with breast cancer before operation. This study shows that there is a need to improve provision for MDMs and to produce guidelines for these meetings.

1. Introduction

The National Cancer Plan published by the UK government in 2000, stressed the importance of multidisciplinary team (MDT) working in the management of cancer patients, stating that patients treated by specialist teams are more likely to survive by improvement of co-ordination and continuity of care for patients. The plan advised that all patients with cancer should be formally reviewed by a specialist team.[1] Following the first European Breast Cancer Conference in 1998, a working party was established to set up guidelines on what should comprise a specialist Breast Cancer Unit. These guidelines state that protected time for surgeons, radiologists, pathologists and oncologists should be allowed for attendance at a weekly team case management and audit meeting.[2] Two years later, the National Institute for Clinical Excellence (NICE) published a report in which it was found that while the concept of MDT working was well developed in breast cancer services in the UK, in practice this was not optimal.[3] This was felt to be due to the fact that both the good internal systems and reliable support required to ensure that all members meet regularly and operate effectively together were lacking. The recommendations put forward by NICE from this report included meetings of the core team on a regular basis (usually weekly) to

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0959-8049/$ - see front matter
doi:10.1016/j.ejca.2005.12.014

discuss each patient with confirmed breast cancer both after initial diagnosis and after surgery, to plan and monitor treatment. Decisions about future treatment should also be discussed at these meetings, in relation to clinical practice guidelines and protocols agreed by the team.

This study aimed to assess current working of multidisciplinary meetings (MDMs) across the UK through surgeons' reports and their current commitments to multidisciplinary breast meetings, and to determine any perceived areas where there was potential for improvement.

2. Patients and methods

Two hundred and fifty questionnaires were posted out to surgeons registered with the British Association of Surgical Oncologists. The anonymous questionnaire contained 12 questions related to MDMs. The questions covered issues including frequency and timing of meetings, attendance, patients covered in discussion, organisation and communication.

3. Results

A total of 153 replies were received (reply rate 61.2%). Hundred and thirty-six of those who replied were involved in treatment of breast cancer patients, of which consultant surgeons comprised 93.4%. The replies were anonymous, and so no interpretation of missing replies, or analysis based upon location or type of unit could be made. All those who replied were involved in multidisciplinary meetings (MDMs). In 80.9% of replies, these MDMs were held once weekly, 13.2% twice weekly and 3.7% thrice weekly. Three surgeons were involved in MDMs less frequently than once every 2 weeks. Only 28% of MDMs were reported as being held during a protected morning or afternoon session. In seven replies meetings were held at breakfast, lunch or evening as protected time. Over half of MDMs were held at lunchtime as an unprotected session (51.5%), or at breakfast (26.5%) or in the evening (6.6%) (Fig. 1).

Attendance at meetings is shown in Fig. 2. Surgeons were present at the whole of the meeting in 98.5% of cases, the remainder of replies stated that surgeons were present for only some of the time. Results were the same for breast care nurses. Radiologists and pathologists were present for the whole meeting in between 90% and 92% of cases and not present at all in only 0.7–1.5% replies. In contrast, clinical oncologists were present for the whole MDM in 70% of cases, and did not attend in 6.6%, while medical oncologists only attended the whole meeting in 44.1%, some of the meeting in 14.7%, and did not attend in 41.2%. Secretaries were present at the whole meeting in 47.1%, but not present at all in 47.8%. Research nurses attended the whole meeting in 53.7%, but research fellows were absent in 72.1% of meetings.

Closer analysis of the data for factors determining the presence or absence of oncologists at the MDMs demonstrated that medical oncologists were more likely to attend some or all of a meeting when it took place during a protected session rather than in unprotected time (71% versus 54%), but oncologists were not more likely to attend if they were involved in selecting patients discussed, or if patients being discussed were pre- or post-surgery for breast cancer.

All breast cancer patients following surgery were discussed at 94.1% of meetings, with 5.1% discussing only selected post-operative cancer patients. In 74.3% of MDMs, newly diagnosed cancer patients were discussed, with selected pre-operative cancer patients discussed in 30.1%. A quarter (25.7%) of meetings discussed selected patients with recurrence, and 70% discuss all patients with cancer recurrence. Selected patients with benign disease were discussed in 74.3% of meetings, with all cases of benign disease discussed in 5.9% (Fig. 3).

The selection of cases for discussion was made by the surgeon in 49.3%, by the oncologist in 33.8%, and by the pathologist in 25.0%. In five instances, the radiologist chose the patients. In half (50.7%) of meetings, all patients were presented so no decision on which cases were to be discussed was necessary.

Surgeons most commonly chaired the MDMs (76.5%), with radiologists leading in 14%, and there was a rotation between all members in 5.9%.

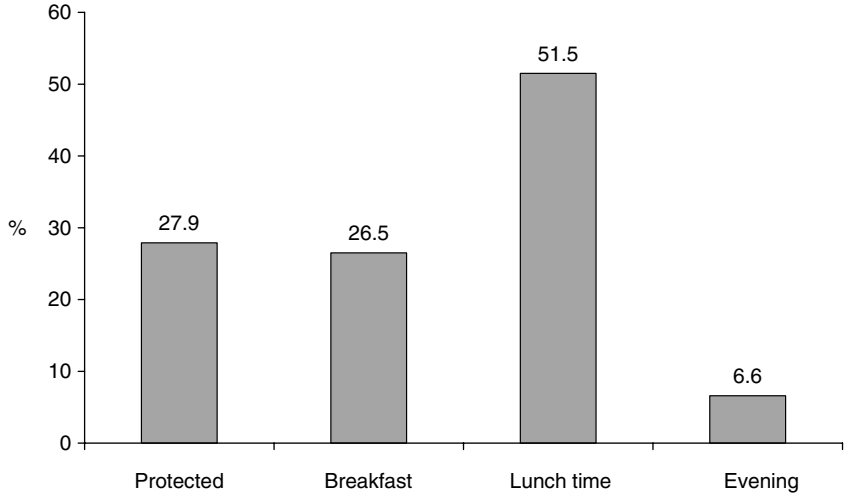

Fig. 1 – Timing of MDMs.

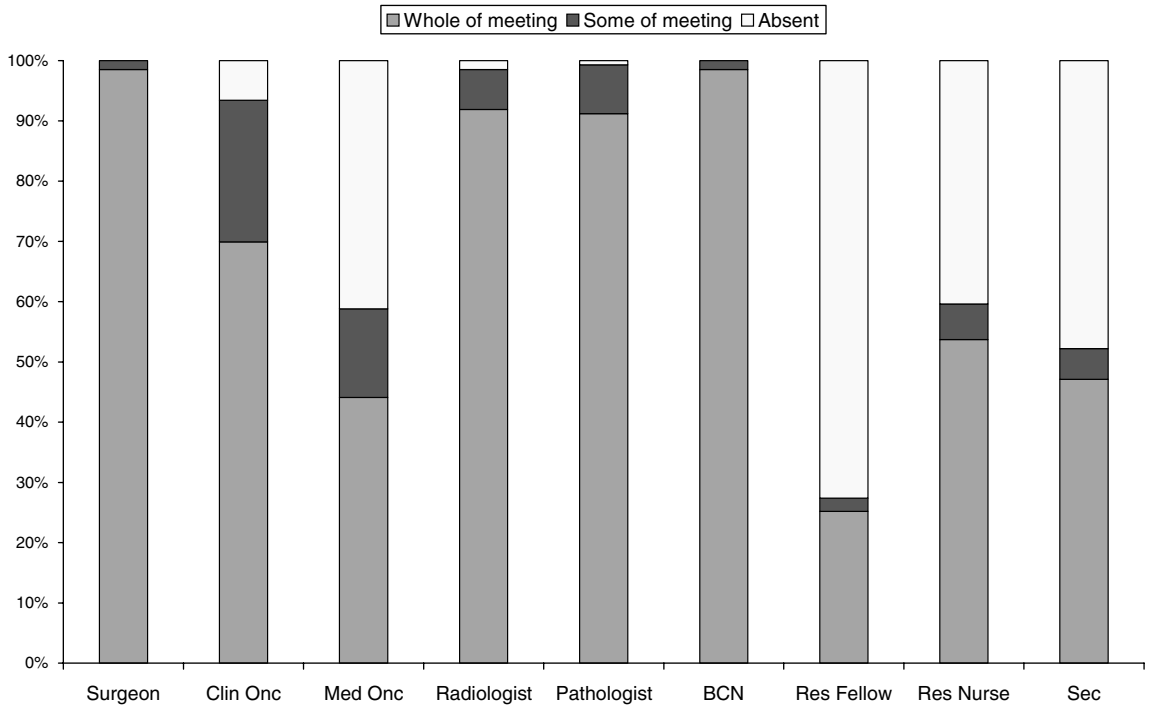

Fig. 2 – Levels of attendance at MDMs.

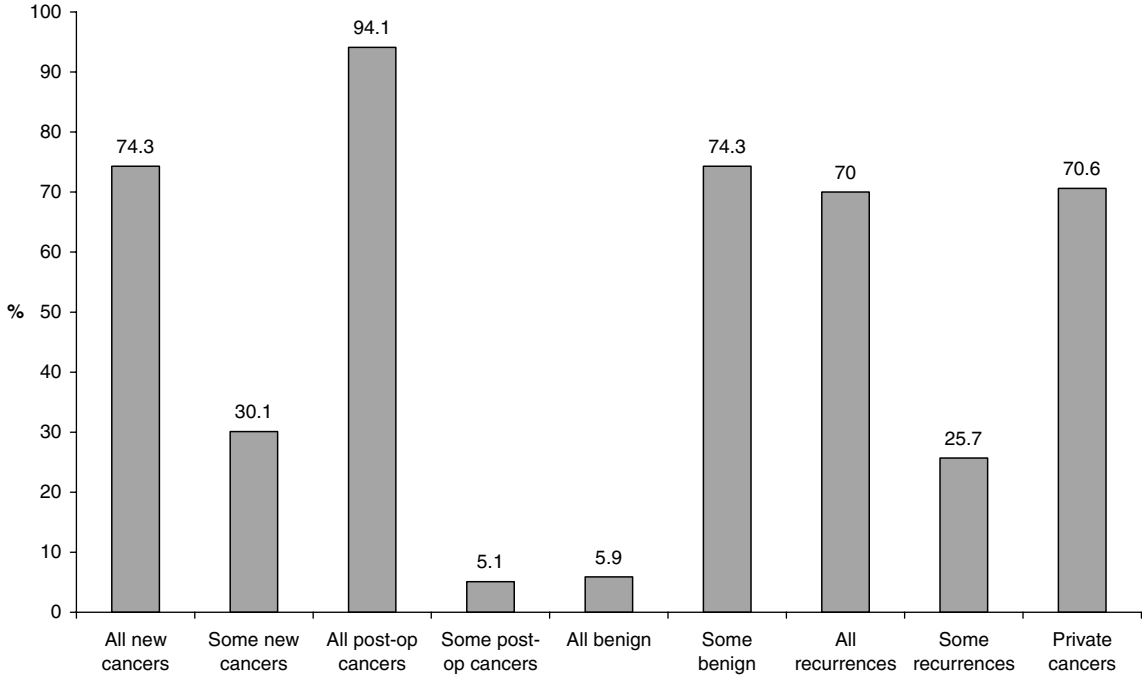

Fig. 3 – Variability of patients discussed at MDMs.

When asked to choose from a list of suggested improvements to MDMs, 72.8% wanted more time for the MDM or for it to be in a protected session. Apart from this, there was no majority of opinion in favour of other changes. Better selection of patients to be discussed (13.2%), better preparation prior to meeting (29%), or allocation of a designated co-ordinator (30.9%) were all considered as likely improvements. A third of those questioned (33.8%) thought that presence of all those involved would improve the meetings.

Of those questioned, 75.7% thought that there was an educational role for trainees at their MDMs.

Recording of decisions made at meetings was performed by a nominated individual recording the information in the routine notes (43.3%), or on a special proforma (50% of meetings). At 31.6% of meetings a typed proforma or record was

produced during the meeting. At 5.9% of meetings there was no formal mechanism for recording the decision of the MDM.

4. Discussion

National targets have been set out in England, Wales and Scotland by the government and by health organisations such as NICE and SIGN, recommending the use of multidisciplinary teams (MDTs) in the care of breast cancer.[3–5] On a European level, EUSOMA have given clear guidelines, which have been interpreted by some as too rigid, on the requirements for a specialist Breast Unit that include weekly meetings in protected time for team meetings, although not specifying the patient groups to be discussed.[2] While there are general rules on how these teams are to function, the most specific guidance is from NICE, directing that meetings should usually be weekly and that all new patients should be discussed, as well as including patients where changes in treatment are considered as their condition changes or progresses.[3] From this study it can be concluded that most MDT meetings occur at least on a weekly basis, thereby fulfilling one of the NICE recommendations, but only 28% of these meetings are carried out as a protected session. In a review by the Clinical Standards Board in Scotland it was recognised that there were frequently key members of the team missing from the clinical multidisciplinary meeting and in an attempt to get around this, several units have multiple meetings throughout the week, each with a slightly different configuration.[5] The recommendation from the clinical standards board was that the MDM should be seen as a clinical commitment as important as clinics or operating sessions, and needs to be included in individual job plans. This is emphasised by a review published by the Joint Collegiate Council for Oncology, which considered the workforce implications of implementing the recommendations of the Calman–Hine report. In this report a new structure was proposed based on a network of expertise in cancer care reaching from primary care through cancer units in district general hospitals to cancer centres. This review based its calculations on the level of service that could be provided by clinical and medical oncologists by including MDT meetings as a clinical session comparable with other clinical commitments.[6]

Having the meeting as a protected session was shown from the surgeons surveyed to be the most valuable way to improve the MDMs that are currently taking place in UK. This is closely connected to the need for attendance of key personnel at these meetings.

While it is acknowledged that there may be a bias in reporting of self-attendance by those completing the survey, there does appear to be a difference in patterns of attendance between surgeons and their clinical and medical oncology colleagues. Seventy-five percent of surgeons felt that there was an educational role for trainees at their meetings. One New York study interviewed staff from six different centres dealing with patients with breast cancer, and found that the perceived benefit of attendance at multi-disciplinary meetings were higher when the meetings aimed to have a direct patient management focused discussion as opposed to an educational focus.[7]

Issues of communication also arose from this study. In 6% of replies, there was no recording of decisions made in the MDM, which raises concern over the decision from the meeting being available for the patient and any members not present. It also raises the question of the relevance of the decisions made at the MDM where they are not recorded.

It can be concluded that the majority of MDMs take place without protected sessions, and that key personnel are not always present at these meetings. The improvements felt by surgeons to be necessary for functional MDMs include protected sessions for these meetings and better attendance by oncologists.

A quarter of units do not discuss patients with breast cancer before operation. This falls outside current national recommendations in UK, which state that patients should be discussed by MDM before and after surgery.[3] There is a need for more detailed advice with regard to organisation and running of MDMs to ensure that all patients with breast cancer can reap the potential benefits of having all aspects of their management discussed at appropriately staffed MDMs.

Conflict of interest statement

None declared.

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