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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

the important features of each case. It is time consuming; if a junior doctor presents a case of a NSCLC, the panel may spend a long time discussing possible resection and then at the end discover that the patient is inoperable due to inadequate lung function. Where junior doctors have to present cases, it can be helpful if they can use a pre-printed sheet with prompts for all the relevant information, thus the presentations would become standardised.

The presentation of the investigations should follow. Professionals attending MDT's must ensure that their contribution remains relevant and concise. This is where a good team leader is essential to stop the meeting being hijacked by an individual who is too fond of the sound of his own voice. Good direction really helps improve the efficiency of the meeting by ensuring that relevant investigations and crucial points are shown in detail and that time is not wasted on those who have little bearing on the discussion. For example, it makes no sense to show histological slides of standard colon cancers, but to define an exact stage of a locally advanced NSCLC it is crucial to show and discuss a CT-scan with a PET-scan in detail, if CT-PET-fusion is not already available. With the attendance of the diagnostic specialities, it will also allow for discussion to establish the best method of obtaining the necessary tissue. A very useful consequence of these discussions between the diagnostic specialities is that it allows clinicians to learn about their abilities and limitations.

4.3. *Reaching a decision*

The MDT acts as a platform for the real discussion and should not be viewed as a meeting point to merely refer patients to the other discipline. It is very time-saving if there are existing, predefined treatment guidelines which have been worked out in a separate meeting from the exponents of the MDT (but these also have to be renewed regularly). Straightforward cases will not require much discussion, thus allowing time to move swiftly on to more controversial cases.

4.4. *Key leadership skills needed to enhance productive discussions*

Characteristics of a good leader include the ability to communicate well with team members (both listening and speaking) and to use a participatory management leadership style, meaning that they should not only be able to get input from different members, utilising their input to reach group consensus and guide decisions, but also be able to make independent decisions when the situation arises. Overall teamwork is more successful when decision-making is visible and participative. Like an orchestra the MDT may have several expert individual players and even soloists but it works best when an expert conductor holds all the members together. Just like the conductor of an orchestra, the leader of the MDT will need some charisma as well as the professional and personal respect of the other team members. When there are difficult or controversial decisions to be made, the conductor must get the best out of all the individual players and then use these to create something that is more than just the sum of the parts.

The discussion itself can be an open one or led in some way; it seems more important that all members can speak with equal voice in an atmosphere of trust and respect as only in the presence of trust will true collaboration flourish. The leader should stop individuals from promoting their own self-interest and ensure that the discussion does not end as a battleground when considering whose opinion is right; rather that every member of the team has something of value to contribute to the patient's treatment plan. The important aspect is to maintain a climate democratic enough so that all ideas about this patient can be openly discussed. A professional leadership together with adequate communication skills will allow this atmosphere of discussion to develop.

4.5. *How to deal with controversies?*

It is still possible that following a frank discussion, there are still different opinions remaining concerning the best patient management and probably two or more opinions sound reasonable. Medicine is not an exact science and different options often exist for an individual patient. Should the leader take the decision? If so it puts him in a difficult position of responsibility. Should the majority make the decision in a democratic fashion? To resolve this issue, it is helpful to consider first the nature of decisions made at an MDT. MDT's without patients present are different from combined clinics where several specialists see patients together. That means the patient has not involved himself in the decision making process so far. Usually professionals attending the MDT may not have seen the patient or understood his condition fully, let alone knowing the opinions of the patient, resulting in decisions made at an MDT being in some way theoretical.

Therefore, it is possible to categorise the decisions made into two groups: Firstly, the decision of the MDT is only a recommendation for the caring doctor, by which this doctor is not necessarily bound. Secondly, the MDT makes a final decision, which can only be changed with a very good reason, for example, if the patient refused the recommended treatment plan.

In the first setting, it is easy to deal with the controversy; the different opinions are given back to the caring doctors to discuss them further with the patient to enable a final decision to be made. If the decision of the MDT is more binding, it will be more difficult to deal with the different opinions. Of course the patient has to be involved in this decision-making process. However, if only one doctor presents the options to the patient there may be a bias. It may be better for the different specialists to discuss the options with the patient in a combined clinic. Sometimes, by seeing the patient and answering their questions, this can prompt the final decision. Maybe complex patients could be seen immediately after the MDT by a small group of key specialists who were present at the MDT.

Another problem may be that the case is discussed, but no final decision is reached, or a decision is made but the reason for this decision remains unclear. Here, the role of the leader is to challenge the professionals by asking the right questions. However, in any team which is striving to reach complex goals, conflicts are inevitable. Conflicts should not always be considered negative and if there is a disagreement, there

could be a need to review the literature, perhaps to get the opinion of a leader in the field outside the MDT and to discuss it again later. If this is done in a constructive way, it can be an excellent learning experience for all involved.

4.6. *Documentation of the decision*

An MDT decision should be entered in some form of minutes, for example, a short annotation in the notes or a specific MDT form. It improves the transparency of the decisions if a clear distinction is made and documented between a generally recommended treatment for this stage of a certain cancer and the proposed treatment for this individual patient, taking further considerations such as poor performance status, age or specific co-morbidity into account. This information can often spare a lot of discussions later and it increases the educational effect. Also, it acts as a prompt when determining who is responsible for introducing the next step, for example, informing the patient about the decision or requesting another investigation.

5. Additional remarks

It is helpful to create a database of the MDT's activity allowing the documentation and easy retrieval of the number of patients with a certain diagnosis and stage. This is obviously helpful to sort out likely accrual rates for new trials or also to carry out retrospective studies or audits.

As mentioned above, the MDT is often the main opportunity for communication between different specialists and it is also a chance to learn from each other. Why not occasionally have a brief presentation concerning new literature about this type of cancer at the end of MDT's? Often surgeons and radiotherapists read different journals to oncologists so that everyone can benefit from each other's knowledge.

6. Conclusion

MDT's are now a key component in a professional's routine and they consume a lot of hours per week. Therefore, we believe it is worthwhile to spend some time thinking about organisations, targets, documentation and collaboration within the group.

Conflict of interest statement

None declared.

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