

The 'value' of multidisciplinary clinics in the management of cancer patients

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Ideally, all cancer patients should be treated by a multidisciplinary team (MDT). Defined in its broadest sense, it "combines or involves several academic disciplines or professional specialisations in an approach to a topic or problem".¹ Achieved by gathering physically in one place or by remote teleconferencing, subspecialists from geriatrics, cardiology, psychiatry, critical care and oncology use this method. Teams may be used to help with both diagnostic and therapeutic dilemmas.

This editorial will focus on the evidence for and against the use of MDTs for the management of cancer in South Africa. However, much of the research evaluating the approach has come from managing breast cancer in the National Health Service (NHS) in the UK.

An MDT approach requires centralisation of resources. Advantages are better adherence to treatment protocols, pooled data, training opportunities, access to drug trials and broad-based care for the patient. The draw backs are logistical challenges, complexity in medicolegal issues and, sometimes, may lead to a delay in the implementation of treatment if all the information is not available for the meeting.²

It is difficult to do a cost analysis of running an MDT. Most studies do not include the immense requirement of preparation and, at best, only calculate the personnel cost. The cost to the NHS was estimated to be about £50 million/year for cancer MDTs alone.³ In 2010, the cost per patient discussed was estimated to be £36.60.⁴ Based on the number of patients discussed in a private Cape Town MDT in a single month, I have estimated the cost to be about R700/patient. (This did not include the cost of preparation for the meeting). Note, however, that there is no remuneration from the health care providers for any of the health personnel who attend MDTs in this country.

It is even more problematic to measure how MDTs affect the cost of treating a patient. A review on economics of MDTs by Ke et al. did not discover any studies for breast cancer patients, but there was a cost saving for the management of melanoma patients of £990, and those with a haematological malignancy cost £3058 less if they were treated by an MDT.⁴

Let us consider the medicolegal status of the MDT. Enquiries were made with both the Medical Protection Society and EthiQal about the medicolegal aspects of MDTs and they gave similar responses. MDTs are not legal bodies. The individual doctor is still responsible for the management of the patient. The slight benefit is that should there be a claim against an individual doctor, where the patient had been discussed at the MDT, it may be easier to defend. Patients do not need to give written permission to be discussed, but they should be informed that they will be discussed at an MDT.⁵

Survival data for women with breast cancer treated by an MDT versus those who have not been is difficult to compare as an MDT is often associated with tertiary level of care and more therapeutic resources. In the 1990s, Glasgow introduced an MDT and compared the outcome of breast cancer patients seen there with those from the rest of Scotland. The 5-year survival of patients seen in the Glasgow MDT improved from 71% to 79%. This compared with the rest of Scotland where the 5-year survival improved from 73% to 75%. Women over 80 years old showed the biggest impact.⁶

The question as to whether these women get the treatment recommended by the MDT was reviewed in a paper published in 2013. Rajan followed up the treatment given to patients and found that 91% received the treatment recommended, 5% were lost to follow-up, 2.25% patients chose not to follow the treatment plan and 2.25% had discordant treatment that could be considered as not justified. The commonest reason for the latter was an incorrect decision made by the MDT due to inaccurate information supplied (usually incomplete investigations).⁷

In the majority of cases, the patient is not present at the time of discussion. Although most diagrams and images of an MDT have the patient at the centre, an MDT process is not the same as shared decision-making where the wishes of the patient are at the centre of the decision-making process. However, a patient-centred approach should be taken when sharing the recommendation from the team.

As survival from cancer increases, survivorship programmes are becoming an integral part of cancer care. The problem with calling them “survivorship” programmes is that if a person develops metastatic disease can they be considered as having “failed” a survivorship programme? Ongoing care should be called comprehensive care. There is considerable debate as to when the palliative care team should be involved. The WHO states that “it is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”⁸ In South Africa, with few palliative care specialists, it is impractical, and their involvement should only be after the development of metastatic disease.

In this country, we have a growing number of genetics counsellors available, but it is not feasible for them to be present at all MDTs. The Royal Marsden has just updated the recommendations for who should be referred for BRCA testing. In brief, the guidelines have been expanded to include any man with breast cancer, any case of non-mucinous ovarian cancer, any women with breast cancer under 40 and any person with a triple negative breast cancer.⁹

Compared to the highly regulated NHS (with protocols in place for the management of most diseases), South Africa, outside the academic sector and few private gynaecology oncology and breast clinics, has few protocols in place and MDTs would therefore ensure more standard management of patients. The logistics involved in many people assembling at the same time in the same place are not to be underestimated. Most of the cancer centres in the teaching hospitals in this country hold

regular MDTs and there are an increasing number of private meetings. The future of comprehensive patient management lies with virtual MDTs. These can be run from anywhere, any time and can include any person with a smart phone. They do not require synchronous timing and so can be held at an individual’s convenience.

As a group of doctors involved with the management of cancer, we should lobby our health care funders in private and in the state to make provision for access to virtual MDTs throughout the country, especially in more rural areas.

References

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