The best decisions come from the best run MDTs

Alberto Costa, Editor

Having just retired from active clinical practice as a breast surgeon, I can look back at how decision making has evolved over the course of my career, from when a single doctor took the decisions, to the multidisciplinary approach we advocate today.

It was in breast cancer, with the discovery of the importance of hormonal receptors, that we first learned that different tumours respond to different types of treatment, and also that we can often limit the surgical damage by bringing additional treatment modalities into play.

The so-called 'collegial' discussion of cases slowly spread to other solid tumours to become the norm. The initial core group – surgeon, radiation oncologist, and medical oncologist – was later expanded to take on board a pathologist, who was needed to define the precise characteristics of the disease.

Once the principle is accepted that four doctors are likely to reach better recommendations than one, you can become five (by bringing a radiologist on board), then six (a dedicated nurse), seven (a plastic surgeon), eight (a psychologist) – and you have a multidisciplinary team. No single doctor can face the complexity of cancer by themself anymore.

The case of prostate cancer is illuminating: where the urologist alone is in charge, the rate of prostatectomies is much higher than where a multidisciplinary team decides. Patients managed by a prostate unit are offered the three treatment options – prostatectomy, radiation therapy, active surveillance – in nearly equal parts, according to their individual disease. In most cases patients feel more comfortable if they know their case has been discussed by several health professionals. It reduces the chance that recommendations are biased by personal factors: Is the doctor a risk taker or risk averse? Optimistic or pessimistic? Keen to recruit patients to a particular trial or try out a new surgical technique? Keen on or hostile to complementary medicine? What are the implications for their bank balance and/or ego?

Science fiction scenarios describe a not-too-distant future where treatment plans will be decided by computers on the basis of patient data and genetic profiles. In the meantime, I believe that the multidisciplinary approach can be expected to improve the quality of cancer care most of the time.

This statement takes for granted, however, that we are talking about multidisciplinary teams that function effectively, where the authority of the team leader derives not just from their knowledge and competence but also their wisdom and human empathy. It means teams that meet regularly to discuss clinical cases that have been prepared with care and made available on time. It means teams that can discuss in a spirit of collaboration, unhindered by egos and by competition between specialties, with each team member taking responsibility for the decisions and nobody zoning out and playing with their iPhone. And it means teams that are committed to making recommendations based not just on the best clinical evidence, but taking full account of their patients' choices and preferences.

If patients could choose their MDT, that's what they would go for.

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