Multidisciplinary Care in the Community Setting

Comprehensive cancer centers facilitate management decisions for newly diagnosed or complex pathology patients by offering medical oncology, radiology, pathology, radiation oncology, surgical oncology, and other services such as pharmacy, nutrition, and social services under one roof. Independent practices, however, are not usually organized to provide a similarly seamless continuum of care. Coordinating consultations with other treating physicians, some of whom may practice at remote or competing institutions, in addition to coordinating receipt and review of diagnostic biopsy material and images while attending to office hours and hospital rounds, can be challenging.

One way independent oncologists offer the advantages of a comprehensive center is through a multidisciplinary cancer clinic. Dan Hayes, MD, is a medical oncologist who practices at Maine Center for Cancer Medicine & Blood Disorders (MCCM) in southern Maine. He has participated in a weekly lung cancer clinic since 1995, when it became generally accepted that adjuvant chemotherapy could play a useful role in the multidisciplinary treatment of lung cancer.

The clinic, which brings together specialists in pulmonology, diagnostic radiology, radiation oncology, thoracic oncology surgery, and medical oncology, grew out of regularly scheduled meetings at which these physicians discussed cases and applied their collective knowledge to clinical trials. “Eventually we reached a critical mass, learning about and from each specialty, and could offer a more thorough and valuable clinical service,” says Dr Hayes. “We decided to provide consultative one-stop shopping, and we began developing a staging and clinical support database because it was the right thing to do for patient care, quality improvement, and physician development.”

In the weekly multidisciplinary conference, the morning is devoted to new case presentations, follow-up discussions, and informational case discussion. A maximum of four “consult” patients are presented. That afternoon, depending on the morning’s conversation, patients see physicians from the specialties who will be involved in their care. Consult notes are added to the patient record to reflect the consensus treatment plan.

A nurse coordinator gathers records, schedules laboratory and radiology studies, coordinates appointments, and provides access to support groups and relevant educational information for patients and families. The clinic has also become a referral repository for other community practices.

The clinic is located in and managed, supported, and funded by Maine Medical Center (MMC). MMC bills for the day’s clinic services and reimburses physicians’ consultation fees.

A useful byproduct of the clinic is its database, which is maintained by the Oncology Information Service (tumor registry) at MMC and records the contribution of each physician involved in a patient’s care. “This electronic clearing house of data can lead to an even greater value for multidisciplinary care than simply a group of doctors representing different specialties making management decisions at any one time,” says Dr Hayes. “It’s the integration piece, the quality improvement piece accomplished through real-time clinical data analysis and decision support, and efficient access to clinical trials.”

The recent addition of a palliative care specialist to the clinic roster supports the recognition that treating lung cancer is often more about alleviating symptoms and improving quality of life than cure. “Because it can be difficult for medical oncologists and radiation oncologists to achieve these goals, it is extremely valuable to include peer subspecialists who own this area to fully support certain patients.”

Dr Hayes considers the patient-centered, systems-oriented lung cancer clinic equivalent to any comprehensive cancer center. “Unlike managing appendicitis or performing a joint replacement, treating lung cancer is a complex process that is ripe for a multidisciplinary approach,” Dr Hayes says. “The clinic allows us to adopt that approach within the independent practice setting.”

Patients who are seen at a multidisciplinary cancer clinic can find it easier to make informed treatment decisions. Physicians who participate in such clinics also benefit from interactions with their colleagues in other disciplines. For Denis Hammond, MD, a medical oncologist who practices at the Hooksett office of New Hampshire Oncology-Hematology (NHOH), participation has taught him about the diverse styles and thinking processes of his colleagues and the integration of care among the specialties. “I now have a better sense of how these pieces fit together,” he says. “And that translates into even better care for all of my patients.”

For the last 2 years, Dr Hammond, in rotation with his partners, has participated in a weekly breast cancer clinic at Exeter Hospital. Other specialties represented include radiology, radiation oncology, pathology, physical therapy, and social services. “An institutional commitment is essential to a clinic’s success,” Dr Hammond says. “In our case, the hospital absorbs the overhead; provides nursing, administrative, and technical support; and handles billing and reimburses doctors for their time.”

Two breast surgeons recruited by the hospital were instrumental in establishing the clinic as a quality care initiative. “A clinic needs a champion—an individual, a practice, or an institution,” Dr Hammond maintains. “It also

needs a skillful coordinator to oversee operations and prevent surprises.”

During the noon hour preceding each clinic, surgeons, who historically provide the first line of breast cancer therapy, present two cases. Following discussion, tentative treatment plans are formulated. That afternoon, during consecutive appointments, a medical oncologist and radiation oncologist see both patients. Following physical examination and discussion with the patient and family, the plans are often refined. This is similar to the findings of the recent University of Michigan Comprehensive Cancer Center Study, whereby more than half of breast cancer patients who sought a second opinion from a multidisciplinary tumor board received a change in their recommended treatment plan.¹ At the conclusion of each Exeter Hospital clinic, the physicians summarize the cases.

Despite the benefits associated with a multidisciplinary clinic, there are potential pitfalls.

- Lack of dedicated support services that unduly burdens practice personnel
- Physicians unwilling to remain flexible with their time
- Conflicts that arise between participating and nonparticipating physicians
- Uncoordinated billing process that overwhelms patients and fails to adequately compensate physicians

Physicians considering the multidisciplinary clinic can heed the advice of seasoned colleagues:

Reference

1. Newman EA, Guest AB, Helvie MA, et al: Changes in surgical management resulting from case review at a breast cancer multidisciplinary tumor board. *Cancer* 107:2346-2351, 2006

- Consider potential objections from “competing” colleagues
- Solicit specialists who are affiliated with a single health system
- Ensure support services; eg, advanced practice nursing, integrated clinical information technology, social services, and palliative care
- Establish the clinic in a centralized, convenient location
- Identify a capable clinic coordinator to oversee administrative logistics
- Develop a vision of best practices and evidence-based care that is amenable to measurable goals

Of utmost importance, securing a “buy-in” from all physicians and services involved helps ensure that disagreements can be managed effectively.

Much of the day-to-day practice of oncology requires care delivered quickly, repeatedly, and in great volume. In contrast, a multidisciplinary oncology clinic requires a commitment to share ideas and clinical data to improve outcomes within the complexities of good cancer care. A well-managed clinic can ensure that patients receive the benefits of the comprehensive cancer center from independent practices within the community setting.

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Multidisciplinary Clinics in Oncology: The Hidden Pitfalls

By Tejpal Gupta, MD

Health care decisions have traditionally been made between a patient and his or her physician. However, as disease management becomes more long-term and complex, as understanding of biology evolves, as therapies improve, and as outcomes become multidimensional, one realizes how limited is the relevance of one’s own specialty in the overall management of a disease in general, and an individual patient in particular. This has led to a shift toward a “multidisciplinary” approach for decision-making in several health care settings, including in oncology.¹ The perceived benefits of multidisciplinary clinics (MDCs) are self-evident and do not merit wider discussion. It is the pitfalls associated with them that generally remain unseen. These merit serious discussion and need to be resolved to promote ethical decision-making in team care.

Advantages of the Multidisciplinary Clinic

The term “multidisciplinary” integrates relevant medical and/or paramedical specialties that have a direct or indirect impact on management. In oncology, the multidisciplinary concept was pioneered by Henry Kaplan and Saul Rosenberg at Stanford University in the 1960s. It is a need-based approach adopted by the oncologic community¹ to facilitate interdisciplinary interaction, foster patient and care-giver confidence, optimize patient care, and help improve outcomes.²

Cancer is not a single disease, and with increasing awareness and emerging options there has been a role reversal for certain specialties in particular cancers. Team members, however, need to balance their individual responsibilities, opinions,