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:

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- 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,

values, decisions, and goals for patient care with their role as a team member with shared decision-making responsibility. Team discussion improves decision making by closing the knowledge gaps of the members. The MDC can be a vital tool to enhance members' skills in a short period of time. Publicity of the MDC's existence is likely to attract more patients, who are likely to be quickly investigated and treated early. This could promote integrated teaching, and lead to the creation of databases to review outcome data. Patients attending such clinics are more likely to be counseled appropriately for accrual into clinical trials. In addition, compliance to decision making can be monitored through the clinic. All this should translate into reduced conflicts with patients and family, and ultimately, into societal benefits. An MDC in oncology with adequate representation from all relevant specialties, with healthy working environment, professional attitude, and voluntary noncoercive participation, can be a vital ingredient to the success of a particular service.

The Hidden Pitfalls

Teams make decisions by lack of response, autocratic choice made by one or two individuals, default, deference to expert opinion, majority vote, consensus, or unanimity.³ MDCs work on horizontal networks, and there is no hierarchy as such. However, as individuals, each person has an ego, which time and again tends to rise to the surface. More often than not, an egoist individual or an egoist group of individuals dominate proceedings and dictate terms in an MDC, rendering the whole exercise farcical and futile. Many a time, when the issue under consideration is highly complex and decision making is difficult, the MDC serves as a useful garb under whose pretext one does actually impose his or her own interpretation of the situation. It can actually be a convenient means of voicing one's own thought process and getting 'consensus' approval such that these decisions are not openly challenged by conscientious individuals or even judiciary. Collective decision making may falsely reduce the sense of individual responsibility for decisions and patient care and lull the members into believing that their decisions are more ethical because they are based on "consensus" opinion.⁴

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Unresolved Issues

The inherent bias in MDCs is reflected in the referral pattern of patients to such joint clinics in major academic centers. Oncologists conveniently refer the "general category" patients to the joint clinic, whereas decision making for the "private category" patient mostly rests with the oncologist with whom the patient is registered. Does this mean that the oncologist is afraid of coming under the scanner for decisions on diagnosis or therapy, which may have been dictated by financial considerations rather than evidence-based medicine? Does this imply that the oncologist does not want to be forced with a decision that may not be in his or her best interest? Does this mean that the same person who is supposed to abide by the MDC decisions on poor, nonpaying patients can exercise his free will on paying private patients? The majority of community hospitals function reasonably well with sound multidisciplinary treatment of cancer, but without the insinuations of a joint clinic. Do patients treated at such centers get suboptimal treatment? Does team discussion result in better-quality decisions?⁵

Conclusion

Decision making in an MDC occurs at the interface between people with varied backgrounds, orientations, interests, and goals. It is important to identify the complex set of variables influencing collective decision making and use this knowledge for maximizing efficiency in health care delivery. The oncologic fraternity needs to be aware of the hidden pitfalls associated with MDCs and find ways and means to effectively circumvent them. A team that functions together cohesively, but at a cost to the patient, is no longer an effective team and needs to refocus on its goals of improving patient care.

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