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Cancer MDTs : do they make a difference?

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MASCC Multinational Association of Supportive Care in Cancer
ISOO International Society of Oral Oncology

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Conflict of Interest Disclosure

Jo Thompson, BSc (Hons), MSc

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Has no real or apparent conflicts of interest to report.

Aims

- Where we are now – the changing face
- Do they make a difference? The evidence
- Issues with the evidence and assessing the impact
- Suggestions for the future

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Background to MDTMs

- Established in the 1990s
- Aimed to:
  - Improve consistency
  - Improve communication
  - Improve clinical outcomes
  - Increase recruitment to trials
  - Improve audit
  - Increase well-being of patients
  - Provide educational opportunities for staff
  - Increase job satisfaction

Background

- When clinicians needed to cooperate more, MDTMs brought people together

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Where are we now?

- 20% increase in patient discussions year on year since 2011 (UK)
- Average number of patients discussed – 15-30
- Over 10% patients need more than one discussion
- Average length of discussion 3-9 minutes
- 10 – 15% recommendations were not implemented
- Failure to reach a decision in 27%-52% cases

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Quality of Care Management Decisions by Multidisciplinary Cancer Teams: A Systematic Review

Benjamin W. Lamb, MRCS[1,2], Katrina F. Brown, PhD[1], Kamal Nagpal, MRCS[1], Charles Vincent James S. A. Green, FRCS (Urol)[2], and Nick Sevdalis, PhD[1]

MEETING PATIENTS' NEEDS

Where are we now?

- Case discussions changed the initial treatment plans in 33% cases – particularly complex cases and recurrence, rare in standard cases
  - (Alexandersson et al 2018 – Sweden)
- Patients often ‘wait’ for a decision until the next MDTM
- Discussions involving 1 or 2 people not uncommon
- Nurses / clinical nurse specialists often did not contribute

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Where we are now ?

- In a working week:
  - 10 – 15% oncologists are in MDTMs
  - 7– 8% radiologists are in MDTMs
- Base cost per patient £428 (average 4 discussions per patient)
- Mean cost per case discussion €212 (91-595)
- Estimated to cost the UK £154.3 million per year

Do they make a difference to outcomes?

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Do they make a difference?

- 138 VA medical centres surveyed (2001- 2004)
- Assessed whether the presence of a tumor board was associated with recommended cancer care, or outcomes

- Found little association
- Acknowledged the variation in makeup of tumor boards

Keating et al (2012)

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Site specific tumours

Tumour site	Evidence for MDTM
Breast	improved survival, unclear which components of the MDT working made a difference
Lung	weak evidence for improved survival
GI	care provided by the MDT (including the MDTM) improved survival compared to care provided by an independent surgeon
GU	no evidence MDTMs made a difference

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Site specific tumours

Gynae	MDTMs led to changes in diagnoses and treatment plans but no evidence on outcomes
H & N	evidence for improved 2 year survival
Colorectal	no evidence MDTMs made a difference

Do they make a difference?

- “The published literature provides little evidence that they actually improve outcomes or survival”
  - Croke & El-Sayed (2012)

- Overall evidence is stronger for changing management than affecting survival

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Patient satisfaction

- Improved satisfaction in national patient experience between 2000 – 2004. Improvements greatest in the most established tumour MDTs (breast, colorectal, lung)

Assessing the evidence

- Difficult to robustly assess

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Assessing the evidence

- Most studies rely on before and after designs – subject to confounding
- Most studies assess the impact on decision-making *rather* than outcomes
- Improvements in outcomes difficult to attribute specifically to MDTMs due to multiple concurrent changes
- MDTMs - complex intervention

Evaluating MDTMs

- “it is always too early (for rigorous evaluation) until, unfortunately it is too late”
  - Buxton’s law (in Munro et al 2015)

The future

- MDTMs somewhat victims of their own success
- Many clinicians frustrated that *every* decision must now go through a meeting
- Agreement that MDTMs can foster education and collegiate working

Suggestions

- Smaller numbers of patients being discussed at face to face meetings (complex cases)
- Consider a ‘triage’ process to decide which patients should be discussed at face to face meetings
- Use electronically based discussions – patients with straightforward problems wouldn’t need to wait for a weekly face to face meeting

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Suggestions

- Consider:
  - communication with primary care (web based?)
  - audit trails
  - evaluation of changes

In summary

- Unclear if cancer MDTMs really do make a difference to patient outcomes

- Considering they are cost and time intensive, the process would benefit from reconsidering and redesigning

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Thank you

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