Multidisciplinary team working: the emperor without clothes?

Multidisciplinary teams have become the format through which the NHS delivers cancer services. They were introduced without high quality evidence as to their effectiveness but have become the accepted 'mode d'emploi' and a standard from which doctors might be reluctant to depart even in response to a valid patient request to do so.

This editorial looks at the history, evidence base and medicolegal requirements associated with multidisciplinary team working to explore whether the accepted norm of case management by multidisciplinary team is justified.

The basis for the introduction and establishment of multidisciplinary teams

Multidisciplinary teams were introduced in England and Wales in 1995 following a recommendation in the Calman–Hine report which devised a team model through which uniformity of cancer care could be delivered. However, few of the studies on which the recommendations were based focused primarily on the effect on outcome of service style and none were clinical trials comparing care models.

Following the Calman–Hine report a range of reports and policy documents were published. The original *Manual of Cancer Services* was issued in 2000 with the aim of both delivering national cancer care standards and also providing a framework for assessment of the quality of that care. Multidisciplinary teams formed a key component of these proposals.

The manual was revised in 2004 to incorporate recommendations including the National Institute for Clinical Excellence's *Improving Outcome Guidelines*. The manual continued to define the characteristics of a good cancer service which included the role of the multidisciplinary team, but made it clear that service characteristics it recommended were not being centrally imposed.

From 2008 new tumour site-specific measures were added to the *Manual of Cancer Services* (Department of Health, 2008). The manual states expressly that its guidance is based on *Improving Outcome Guidelines* and is exactly that – 'guidance'. Despite this, the guidance in relation to multidisciplinary teams is so specific, and delivered in such close association with the process of national peer review, that it was generally implemented as though it was prescriptive policy. Thus, without a clear evidence base, service delivery by multidisciplinary team was embedded and accepted as an operational requirement.

Evidenced benefit or accepted belief?

The consensus is that multidisciplinary teams are a good thing. This consensus seems to be rooted in a number of presumed benefits, including the assurance that all patients receive timely treatment and care from appropriately skilled professionals, that there is continuity of care, that patients get adequate information and support, and that reliable data can be collected. It is also presumed that multidisciplinary teams optimize effective use of resources and improve recruitment into clinical trials. Another popular justification of the multidisciplinary team format is that it offers a safeguard to both patients (from maverick doctors) and doctors (by achieving a treatment plan for which no individual clinician takes personal, legal responsibility).

Few of the presumed benefits of multidisciplinary teams have been proven. A review of the evidence for the effectiveness of multidisciplinary teams concluded that although the vast majority of multidisciplinary team attendees believed that team working improved standards of patient care and treatment, the studies in which these views were gathered were of weak design, so gave weak evidence (Taylor et al, 2010).

The majority of evidence in favour of multidisciplinary organization is either observational (Gabel et al, 1997; Chang et al, 2001), inferred (Picker Institute Europe, 2005) or shows only that working in a multidisciplinary team is less stressful for participants than not working in one (Taylor and Ramirez, 2009). There is weak evidence that multidisciplinary working is associated with improved survival in some cancers (Eaker et al, 2005; Morris et al, 2006; Stephens et al, 2006; Coory et al, 2008), but as these were not prospective trials, it is not possible to know whether it is the multidisciplinary team format which effected the improvements or better adherence to treatment guidelines and/or routine involvement of specialists.

Despite the lack of clear supporting evidence, the view that multidisciplinary team working is prescribed and evidence based has been widely promulgated. The letter of introduction published with the 2004 *Manual for Cancer Services* describes the structure and process, of which multidisciplinary teams form a core part, as being evidence based (Department of Health, 2004), but does not identify this evidence. Similarly, patient information about multidisciplinary teams on the Macmillan website lists multidisciplinary team benefits which are said to be evidence based. Again, the evidence is not identified and could not be provided when specifically requested.

Potential multidisciplinary team limitations

Against the perceived benefits of the multidisciplinary team there are a number of potential downsides and concerns.

The size of multidisciplinary teams is large; on average there are 14 attendees of whom 10 are consultants, one a junior doctor and three are 'others' (nurses, radiographers, pharmacy workers and clerical staff). The average meeting length was 2.14 hours to discuss 31 cases, allowing an average of 4 minutes per case (Fosker and Dodwell, 2010). In accordance with the *Manual of Cancer Services*, all newly diagnosed cancers are discussed at multidisciplinary team meetings, but there is no similar guideline for cases of metastatic or progressive cancer. These cases, which are commonly more

complex, are discussed at multidisciplinary teams arbitrarily and not routinely.

Given these data it might not be unreasonable to conclude that the multidisciplinary team format is a time-consuming and costly way of delivering treatment plans that is skewed in favour of routine cases.

For practical reasons, confidentiality and the concern that fast-moving and explicit discussion about risk and prognosis might distress patients, the multidisciplinary team process does not allow for the presence of patients and their involvement in making decisions regarding their treatment. Whether deciding a patient's treatment without his/her input meets the General Medical Council (2009) good practice requirements of sharing information and discussing treatment options is likely to depend on whether the patient has explicitly consented to waiving his/her right. It seems likely that many patients either do not know that their care will be discussed by a multidisciplinary team or are unaware of its composition. In particular, they are unlikely to know that it includes attendees who do not make up core members of the team, the likely number of team members actually involved or the small amount of time their case is likely to receive.

There is also the matter of medical confidentiality. The Data Protection Act 1998 provides a general requirement that a data subject's specific consent to processing must be obtained. It does, however, allow for the processing of sensitive data without consent if it is, inter alia, processed by a person subject to an obligation of secrecy equivalent to that of a health professional and is being used for medical diagnosis or the provision of care and treatment.

The General Medical Council endorses this approach by allowing certain exceptions to the strict duty to treat information about patients as confidential. One such exception is to permit the disclosure of information with the patient's consent – express or implied. Implied consent is presumed when a patient's data are being shared with a health-care team or with others providing care, although specific direction is given which requires that (i) doctors '…should consider whether patients would be surprised to learn how their information is being used and disclosed' and (ii) that a patient's wishes must be respected if he/she objects, unless disclosure would be justified in the public interest. There is provision to refuse treatment if it cannot be arranged safely without the disclosure to which the patient objects but it seems unlikely that this would be the case if the objection was to the data being shared with the wider multidisciplinary team but not a more restrictive selection of strictly relevant health professionals.

Some multidisciplinary teams sidestep the confidentiality issue by requiring that unless the multidisciplinary team meetings are restricted to core members the discussion has to take place without disclosing the identity of the patient, using only the initials and date of birth (Davis, 2007). This is not currently a procedure followed by all multidisciplinary teams, nor is it a procedure many are able to accommodate on a case-by-case basis if asked to do so by an informed patient.

Conclusions

There is no clarity about whether improvements in the standards of cancer care are the result of the multidisciplinary team format. Nor is it clear whether the perceived benefits of multidisciplinary team working can be derived only from multidisciplinary team organization rather than any other form of team working. What is clear is that the downsides of the multidisciplinary team have yet to be fully explored and quantified so that they can be improved or alternatives can be considered. Like the subjects of the Emperor in the Hans Andersen fairy tale, we have been encouraged to accept a largely unsubstantiated myth. Perhaps it is now time to question the accepted belief and look anew at whether multidisciplinary team working represents the optimum. BJHM

KEY POINTS

- Multidisciplinary teams have become the accepted 'mode d'emploi' despite having no clear evidence base and there being no prescriptive requirement to implement them.
- Few of the presumed benefits of multidisciplinary teams have been proven or shown to be benefits which can be derived only from multidisciplinary team organization.
- Against the perceived benefits there are unresolved concerns relating to cost, patient benefit and issues of consent and confidentiality.
- Multidisciplinary team working has downsides which have yet to be fully quantified so that either their resolution can improve the multidisciplinary team system or alternatives can be considered.

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