Multidisciplinary team working

Sir,

It is unsurprising that the introduction of multidisciplinary teams has led to various commentaries about their value, especially given the expense they incur (vol 73(4), 2012, p. 186). The lack of strong evidence of benefit of multidisciplinary teams should not, however, be equated with lack of benefit – we cannot conduct definitive randomized controlled trials now that multidisciplinary teams are accepted as standard but accumulating evidence from observational and quasi-experimental designs suggests multidisciplinary team working is related to better decision making and clinical outcomes (Taylor et al, 2010; Lamb et al, 2011; Kesson et al, 2012).

Now that multidisciplinary teams are well established we should perhaps instead focus attention on ensuring they are working as intended and address the wide variation in performance (National Cancer Action Team, 2010). Many commentaries fail to distinguish between multidisciplinary teams and multidisciplinary team meetings when critiquing their use and purpose. It may be that the multidisciplinary team meeting model requires refinement to reach its potential, but few cancer professionals would deny that multidisciplinary teams are necessary for comprehensive high quality patient care.

The management of patients with metastatic or progressive disease is currently under review by a sub-committee of the multidisciplinary team development steering group, part of the National Cancer Action Team. Comprehensive case preparation based on agreed minimum datasets (including patient-based information such as views, needs, comorbidities) would facilitate high quality discussions, and enable prioritization of these and other complex cases. This may be at odds with the rush to meet waiting times' targets.

Multidisciplinary teams make recommendations – not decisions – but for patients to be meaningfully involved in decision making they need to be adequately informed about the process and purpose of the multidisciplinary team meeting. Patients the authors have interviewed reported lacking knowledge of the multidisciplinary team and their meetings and felt greatly reassured to know recommendations for their treatment arose from a team of experts, rather than raising confidentiality and/or data protection issues. Multidisciplinary teams may have a few areas that need enhancing but this should not preclude their many strengths.

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Sir,

It is sensible to stop and take stock periodically to critically appraise whether accepted systems of health care are delivering worthwhile outcomes, as highlighted by Thornton and Dodwell. Multidisciplinary team working is currently in the spotlight (Brown, 2012; Kesson et al, 2012). It is instructive to consider an appraisal by Grilli (2001) where multidisciplinary team working was sensitively explored in connection with specialized care of breast cancer patients, in order to inform health policy. Paucity of evidence was noted then, as was the difficulty of disentangling the different components one from another, and caution advised in the interpretation of the limited evidence available.

Brown (2012) also describes the 'inability to disentangle the effects of confounders such as socioeconomic status and health service deprivation, heterogeneity of tumour stage when comparing patients before and after implementation of a multidisciplinary approach, and inherent improvements in cancer treatments over time'. Citing Kesson et al's (2012) evidence, Brown (2012) opines that the multiple skills of multidisciplinary teams will become even more necessary.

My view is inevitably coloured by my own experience of multidisciplinary team working in 1991 when treated in Colchester by the team set up by Mr Neil Orr – complete with breast care nurses (Thornton, 1992), pre Calman–Hine recommendations. Since then there have been numerous changes not only in health-care delivery systems and all technological aspects, but also in the doctor–patient relationship, in shared decision-making, and in social and cultural attitudes generally. In these difficult economic times, it seems that any attempts to evaluate multidisciplinary team working should, as Grilli (2001) suggested, be rigorous, wide-ranging and cautious, and should include contributions of representatives from all stakeholders, including well-informed patients and citizens.

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Sir,

We do not equate lack of evidence with lack of benefit as suggested by Taylor and Green in their response but remain of the view that lack of evidence means that no assumptions about benefit can be made. Our concern is that benefit is widely assumed despite the lack of clear evidence. This point is understood and reiterated by Hazel Thornton in her reply.