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.

Hazel Thornton also refers to the recently published research which attempts to correlate the effects of multidisciplinary working on survival by Kesson, highlighting that, despite the authors' acknowledgement that their results 'might have been due to bias and confounding factors', the findings were interpreted immediately and implicitly in the accompanying editorial as being supportive of multidisciplinary team working (Brown, 2012). This editorial went on to use the relatively weak evidence of the Kesson study as a basis from which to articulate many of the assumed but unproven benefits of the multidisciplinary team format. It therefore seems to fall into the very category of multidisciplinary team justification of which we are critical.

Taylor and Green accept that the multidisciplinary team model requires refinement but make this subject to the preference they perceive cancer professionals have for multidisciplinary teams. This preference is evidenced only in terms of multidisciplinary team membership being less stressful for participants. A review of 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 those views were gathered were of weak design (Taylor et al, 2010). There is, therefore, little justification for allowing the perception of cancer professionals to override the need for critical appraisal of the multidisciplinary team system.

The degree of reliance Taylor and Green place on their informal interviewing of patients may be misplaced. One might wonder whether the patients who were 'greatly reassured' by the multidisciplinary team format were given enough information about multidisciplinary teams to be said to understand them sufficiently to give informed comment about them. Were they, for example, aware of the average constitution of the multidisciplinary team, that their case receives an average of only 4 minutes consideration, or what the consent and data issues involved might be? Patient respondents would need to have been apprised of all the facts before being asked their view or the findings of the interviews may not reflect true opinion.

Taylor and Green make the distinction that multidisciplinary teams make 'recommendations' not 'decisions'. A different terminology does little to change the point that the treatment plan is arrived at by the multidisciplinary team without the involvement of the patient.

The quality of evidence, including the recent Kesson study, as to the effectiveness of multidisciplinary teams remains poor and many presumptions of benefit persist. Numerous unresolved concerns relating to cost, patient benefit and issues of consent and confidentiality have been identified. Critical appraisal is warranted.

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Hypertension-related, but not necessarily age-related

Sir,

Although it is well recognized that both dementia (Barnes and Yaffe, 2011) and non-valvular atrial fibrillation (Go et al, 2001) have a sizeable age-related component, it also needs to be recognized that, to a certain extent, it is the duration of exposure to a risk factor, such as hypertension, rather than age per se, which accounts for these disorders being more prevalent in the old than in the young.

Accordingly, where dementia is attributable to vascular factors (Barnes and Yaffe, 2011), and where non-valvular atrial fibrillation is attributable to hypertension (Go et al, 2001), there is the potential for the age-related prevalence of these disorders to be reduced if young adults receive early diagnosis and treatment of hypertension. This can be achieved through population screening of adults (right down to the age of 18 years) (US Preventive Services Task Force, 2003), even though this strategy has not been specifically endorsed by the National Institute for Health and Clinical Excellence (2011).

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