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# Multidisciplinary teamwork in urological oncology

'...all urological cancer patients should be managed by a multidisciplinary team.'

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The cancer pathway, from primary-care referral to specialist consultation, diagnostic test(s), decision to treat, treatment itself and, invariably, life-long follow-up, has the main aim of curing a patient with minimal morbidity, while maintaining their physical and psychological wellbeing. Recently, in the UK it was recommended that improvements in cancer outcome can be achieved through major organizational changes in cancer care by reorganizing cancer services into 'cancer networks' and adopting significant changes in professional practice through the promotion of specialization by individual consultants, a multidisciplinary approach and shared clinical protocols [101].

In urological oncology, it was recommended that all cancer patients should be managed by a multidisciplinary urological cancer team [102]. Taking this mandate forward, patterns of clinical practice have changed and at the heart of modern urological cancer care is the multidisciplinary team (MDT). The MDT consists of:

- Consultant urologists;
- Clinical and medical oncologists;
- Radiologists with expertise in urological cancers to perform imaging investigations in accordance with the Royal College of Radiologists' Guidelines [1];
- A specialist uropathologist who reports on all the information required by the current Royal College of Pathologists' minimum dataset for the relevant cancer [103];
- Clinical nurse specialists who have a high level of skill in communication. Patient advocacy and provision of information and support for patients and carers are crucial aspects of this role;
- An MDT coordinator, who organizes the weekly meeting and ensures that all required documentation is available at each meeting (e.g., patient lists and case notes);
- A designated lead clinician (normally a consultant urologist) who will take overall responsibility for the service.

According to the Guidance on Cancer Services: Improving Outcomes in Urological Cancers paper, the main roles of the MDT are:

Provision of a rapid diagnostic and assessment service, including satisfying the 2-week-wait criterion [104];

- Identification and management of all patients with urological cancers;
- Provision of treatment and follow-up for these patients;
- Provision of a rapid-referral service for patients who require specialist management;
- Liaison with primary care teams, specialist teams, services for the elderly and voluntary organizations, such as hospices;
- Ensuring that General Practitioners are given prompt and full information about any changes in their patients' illness or treatment;
- Collection of data for network-wide audits [102].

To achieve these goals, there is very close and coordinated cooperation between all members of the team. For example, from the initial point of diagnosis of malignancy, the patient's journey is guided, coordinated and monitored in a holistic manner by the work of the MDT. Patient contact and involvement is centered throughout this pathway.

In our department, the MDT meet formally on a weekly basis to discuss various aspects of patient management – primarily diagnosis and

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treatment options. The case notes, along with diagnostic, staging and pathology information of all patients to be discussed, are brought to the meeting. Attendance at meetings is recognized as a clinical commitment and team members must prepare adequately so that they can discuss each case without delay. No decision is taken in an arbitrary manner colored by an individual's specialization, but is based on current best evidence and the wide knowledge base of all of the members of the MDT. Thus, a patient gains unbiased access to a range of options that may be suitable for their individual case. In addition, the MDT ensures that local guidelines and protocols are adhered to in all decision making, thus reducing variations in management. It has been suggested that the MDT meetings improve the communication between all professionals involved, which is beneficial for the patient and also results in increased levels of knowledge and skill for all participants [102]. One of the major advantages of the MDT meeting is that it can act as a forum to share the burden of decision making in difficult clinical situations. Furthermore, it acts as an audit of management by a panel of peers.

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In our department, suitable facilities have also been provided to support effective and efficient team working, including video conferencing facilities and digital radiology imaging. Furthermore, improvements in the effectiveness of MDT meetings, in particular discussing patients with prostate cancer, have been reported by the Cancer Services Collaborative in England [105]. Poor attendance by team members and a failure to discuss all of the patients who should have been discussed were seen as the main problems. These were overcome by improving teambuilding through the involvement of all team members in discussions regarding meetings, and the introduction of effective systems to ensure that all new patients were discussed and that necessary information was available for every patient at each meeting. Documentation was improved using a *pro forma* developed specifically for these meetings. Reports have suggested that a dramatic increase in the percentage of patients who are managed in accordance with clinical guidelines can be achieved: from 10% before the introduction of the MDT *pro forma* and action to ensure the availability of patients' notes to 100% 8 months later. More recently, multifunctional databases have been suggested to improve National Health Service administration and patient care [2,3].

Although some sources suggest that the workings of the MDT are a mere rubber-stamping exercise, it must be remembered that significant inconsistency can occur when choosing treatment options for identical patients outside the framework of the MDT [4]. A quote by Benjamin Franklin, which may well be adopted by many departments, is very pertinent to the MDT management of urological cancers: "We must indeed all hang together or, most assuredly, we shall all hang separately". There is some merit in remembering this when dealing with the complex nature of urological oncology cases.

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