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The Clinical Need for Standardised MDM Assessment Processes

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We read with interest the article by Johnson et al. regarding the development of a peer-review framework for cancer multidisciplinary meetings (MDMs)¹. MDMs are a critical component of multidisciplinary oncological care, associated with improved patient outcomes and satisfaction, trials recruitment, and interdisciplinary communication²⁻⁵. Whilst national and international guidelines exist relating to the conduct of MDMs^{3,6,7}, processes still vary within and across institutions, differing in MDM frequency, the patients presented, team membership, leadership and communication^{2,4}. There is currently no standardised process within Australia to monitor the quality of MDM across different institutions and regional settings. However, variations between MDMs may affect quality of care.

We recently reviewed neoadjuvant chemotherapy delivery for muscle-invasive bladder carcinoma (MIBC) in a metropolitan and regional setting and found MDM discussion to be a determinant of patients receiving neoadjuvant chemotherapy. Neoadjuvant chemotherapy is standard of care for patients with MIBC⁸. Our retrospective audit analysed 19 metropolitan patients and 23 regional patients who underwent radical cystectomy for MIBC. Regional patients had significantly lower rates of both referral to a pre-operative MDM (84% vs 42%, $p=0.023$) and neoadjuvant chemotherapy (42% vs 13%, $p=0.043$). Nine of the 11 patients (82%) who received neoadjuvant chemotherapy had been discussed at a MDM, demonstrating the association between MDM referral and neoadjuvant treatment. There were no significant differences identified in the patient populations or type of chemotherapy. Optimising the MDM processes could therefore improve delivery of standard of care treatment for these patients.

Whilst it is intuitive to believe that an MDM that meets regularly, with well-considered terms of reference, strong leadership and good team communication will make better decisions, there is minimal literature comparing variations or interventions in MDM processes and their effect on patient outcomes. Lamb et al. demonstrated that use of a checklist during MDM discussion to

ensure adequate information was presented and all team members' views discussed, improved efficiency and treatment decisions. There was no measure as to whether this translated into improved patient outcomes⁹. The MDM peer-review framework described by Johnson et al. is another tool, designed to reduce variation in practice and provide opportunity for quality improvement. It may be limited by the labour-intensive process and the perceived relevance of its recommendations¹⁰.

We strongly support ongoing research into improving the quality and efficiency of the MDM process. We argue that for any MDM intervention, improved patient outcomes should be the primary measure of success. Whilst a peer review process enables assessment of communication and leadership within an MDM team, we wonder whether less costly strategies should be explored first. Our research would suggest that process to ensure that all patients are discussed at an MDM soon after their diagnosis, which are attended (either in person or via teleconference) by all appropriate specialists, would be a welcome first step. It would be interesting to investigate whether a simple checklist used during the MDM to prompt discussion could further improve patient outcomes.

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