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European Association of Urology



Words of Wisdom

Re: Determinants of Variable Resource Use for Multidisciplinary Team Meetings in Cancer Care

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Experts' summary:

This study aimed to find the cost of multidisciplinary team meetings (MDTMs) in Swedish cancer care. Fifty MDTMs were observed, 22 at a university hospital and 28 in county hospitals. Of these, 24 MDTMs were video-based. Five meetings were for urological cancer cases.

The mean meeting time for video-based MDTMs was 1.14 h (0.25–2.75) and a mean of 12.7 cases were discussed. Meeting time was significantly influenced by cancer type, hospital type, and video-based versus non-video-based meetings. Physicians reported mean times of 1.84 h for preparation, 1.07 h for participation, and 1.23 h for post-MDTM work per meeting. The time required for preparation was significantly longer for pathologists (mean 2.4 h) and radiologists (mean 3.4 h) than for surgeons (mean 1.55 h). Physician costs accounted for 84% of the overall cost [1].

Experts' comments:

MDTMs have been adopted in almost all fields of medicine without generally accepted aims and principles for running them or evidence of a benefit in terms of cancer treatment outcomes [2].

MDTMs are a new way of making clinical decisions. In Scandinavia, MDTMs have become an integrated part of “packet courses”, which means that patients suspected of having a urological malignancy are guaranteed to be seen within a few weeks. The system requires prescheduled outpatient visits and operating room times, and works as if patients are given a gold card to pass through the hospital before other patients who are waiting for treatment. Every step in these packet courses is intensively monitored by health authorities, and the resource demands have made packet courses and MDTMs cuckoos in the urological nest.

The study by Alexandersson et al provides data on resource usage for MDTMs.

We do not believe that a large group of people of whom only a few know the patient well can make better clinical decisions than a certified urologist who is familiar with the European Association of Urology guidelines and seeks advice from a fellow urologist or oncologist when needed. Displaying pathology and radiology findings on screens does not add extra information to a report that is already signed by two specialists. Resources used on oncological MDTMs and fast track courses should not be taken from other urological patients. MDTMs should be reserved for clinical situations for which decisions have a significant impact on prognosis, such as sepsis, Fournier's gangrene, chronic pain syndromes, major trauma, and neurourological disorders. The role of MDTMs needs to be discussed in the urological community.

Conflicts of interest: The authors have nothing to disclose.

References

- [1] Alexandersson N, Rosell L, Wihl J, Ohlsson B, Steen Carlsson K, Nilbert M. Determinants of variable resource use for multidisciplinary team meetings in cancer care. *Acta Oncol* 2018;57:675–80.
- [2] Reeves S, Pelone F, Harrison R, Goldman J, Zwarenstein M. Interprofessional collaboration to improve professional practice and health-care outcomes. *Cochrane Database Syst Rev* 2017;2017:CD000072.

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