



Correspondence

Patient involvement and shared decision-making in the management of back pain: a proposed multidisciplinary team model



Sir—The delivery of personalised medicine is a key initiative for modern healthcare organisations.¹ Decisions about a patient's investigation and treatment are no longer made *for* them, but *with* them, and due consideration is given to the variety of socio-economic, cultural, and personal reasons that influence a patient's management.² The incorporation of patients into the decision-making process is increasingly recognised to be an important duty of physicians, not only for reasons pertaining to patient autonomy,² but also for its benefits to the clinical decision-making process and clinical outcome.

In the context of degenerative spine disease, the incorporation of patients into the decision-making process is especially important. The presence of an imaging finding is insufficient justification for surgery to be planned. The decision to treat is critically based upon the extent to which patients are affected by their symptoms, as it is possible to have marked musculoskeletal changes on imaging but be relatively asymptomatic and vice versa.^{3,4} Furthermore, pain is not a binary experience. It is on a continuous scale and varies in location and time. For this disease spectrum, imaging is only part of the story, and in each case the radiological findings must be correlated with the individual patient experience to determine the optimal management.

Traditionally, back pain investigation begins with a request from the orthopaedic surgeon, rheumatologist, or general practitioner to the radiology department. The imaging findings are reported by the radiologist, taking into account the context provided by prior imaging studies and the available clinical history. The clinical history contained on the request card is an understandably *précised* version, perhaps only representing the patient's symptomatology on the day they saw the referring clinician, and therefore not an accurate portrayal of their overall experience. After the scan is reported, it falls to the clinician to integrate the imaging findings with the clinical presentation, as best can be ascertained from memory and the documentation in the notes. The radiologist is not present at this time and any questionable imaging findings that require "clinical correlation" cannot be discussed with the reporter. Even when clinicians and radiologists meet in a multidisciplinary team (MDT) meeting, there is still uncertainty about the

significance of all the intercurrent degenerative changes that may or may not be causing symptoms. A follow-up outpatient appointment is often necessitated to re-discuss equivocal findings with the patient. Ultimately, this disjointed process results in a decision that does not fully encompass the individual patient's symptoms.

To combat the described flaws with the current multidisciplinary model, we propose a novel approach to the management of patients with back pain, termed the Patient Incorporated Multidisciplinary Team (PI-MDT). In the traditional model, the various players: the patient, the referring clinician, and the radiologist are separated in time and space. The new model, which we have instituted at our hospital, brings all parties to a single forum thereby maximising the chance of achieving the best possible outcome for the patient.

The presence of the patient at the PI-MDT allows the history to be precisely conveyed and permits real-time correlation of any equivocal imaging findings. The ability to collect relevant clinical information during the meeting itself can reduce the need for an outpatient appointment, thereby optimising working patterns.

From the patients' perspective, their attendance at the meeting allows them to better understand the nature of their condition and how treatment decisions are made. Furthermore, the visual presentation of pathology can help bring home the relative severity of their condition, therefore making them more likely to engage with the proposed treatment. This is especially important with back pain as rehabilitation, exercise, and lifestyle changes form key parts of the management. By providing a platform for patients to gain insight into their disease burden, and helping them contribute to a shared treatment plan, this model is in line with directives from The National Institute for Health and Care Excellence (NICE).⁵

The PI-MDT would also benefit the radiologist, as they could receive real-time feedback on the significance of their findings and derive professional satisfaction from seeing the impact of their contribution. This proposed model provides a platform for increased face-to-face interaction and a greater public understanding of the role of radiologists^{6,7}.

The inclusion of patients into the MDT meeting is not without its pitfalls. Having a patient present would inevitably make the meeting longer. Consideration would therefore have to be given to adjusting the job plans of the treating clinicians, the radiologist, the secretarial staff, and any others present at the PI-MDT meeting.

The presence of a patient at the MDT meeting could be perceived as a hindrance to the decision-making process. As the patient needs to follow the discussion, lay terminology must be used. Although simple word substitution will often suffice, clinicians should provide more detailed explanations when needed.

Some clinicians may feel uncomfortable discussing certain aspects of care in front of patients. For example, decisions on operative suitability may hinge upon weight loss and the relatively public forum of an MDT meeting may not be the most appropriate environment for such discussions. In addition, clinicians may not feel able to disagree with colleagues in the presence of a patient; therefore, discussions may be prematurely curtailed. Patients are not traditionally privy to the frank exchange of views that can sometimes precede contentious management decisions. Healthcare professionals should be conscious that the tone of their discussion could undermine a patient's confidence in the final outcome. Although these points do not preclude the incorporation of patients into the MDT meeting, they do require clinicians to be mindful of their presence.

The nature of the doctor–patient relationship has undergone a considerable shift in modern medicine, with paternalistic medicine giving way to greater patient autonomy and shared decision-making. Our PI-MDT model puts the patient experience at the heart of the discussion around their treatment and would allow clinical correlation to be obtained in real-time. We believe that the proposed

model has benefits for patients, clinicians, and radiologists, and suggest that formal evaluation be undertaken.

Conflict of interest

None.

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