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October 2016

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Recommended Citation

Abbasi, A. N. (2016). Establishment and maintenance of quality of site-specific multidisciplinary tumor boards in Pakistan. *Journal of the College of Physicians and Surgeons Pakistan, 26*(10), 805-807.

Available at: https://ecommons.aku.edu/pakistan_fhs_mc_radiat_oncol/38

EDITORIAL

Establishment and Maintenance of Quality of Site-Specific Multidisciplinary Tumor Boards in Pakistan

Ahmed Nadeem Abbasi

Establishment of site-specific multidisciplinary tumor boards is being taken up as a healthcare goal by institutes providing cancer care in Pakistan and other countries of the SAARC region. Over a period of time, the real benefits of these tumor boards have been witnessed in terms of better quality care of cancer patients. In the western countries, like the United Kingdom, these multidisciplinary meetings are mandatory events and they have already gone through the establishment phase of this important patient-centred activity. We, practising in LMI (Low and Medium Income) countries, are still embracing this idea and are a bit slow in adopting this change. Most of the time, it is the lack of clinicians' time being used as a primary excuse quoted in defence of inexistence of these site-specific boards. This is high time that those who are committed to provide best quality healthcare to their cancer patients would satisfy the global standards and quality benchmarks. Peer reviewed practices were being adapted as standard of care; and site-specific multidisciplinary tumor boards are an important integral component of a comprehensive patient-centred care plan.

The question of mandatory inclusion of all cases for discussion in these proposed site-specific tumor boards is not answered yet. In the atmosphere of present-day clinical practice, this notion of mandatory inclusion of all cancer cases sounds like an impossible task. Therefore, realising the ground reality situation and background practical scene, reluctantly, one can think about making a selection of relevant cases for discussion in these tumor boards. From a perfectionist's perspective, the ideal wish is to bring a cultural change in our healthcare system in a day *via* a magic wand. Unfortunately, the reality is that, the clinicians are not in any authoritative position to implement this change which will turn round the local cancer care practice by 180 degrees. Therefore, staying in the real world, what can be suggested is a team-building approach to proceed with one step at a time; and on voluntary basis, start establishing these tumor boards in our institutions. This requires a core backup of colleagues who wish to bring their cases for discussion, seeking consensus opinion with multidisciplinary expert input.

The whole question of quality of these tumor boards needs to be addressed as well. Fortunately, there are healthcare institutions in the country which are taking the pains for getting certifications and accreditations of quality health systems via independent third party auditors like JCIA (Joint Commission for International Accreditation), I.S.O., etc. It is expected to see faster steps in this ongoing uphill course in institutes across the region. National Health Service (NHS) of the United Kingdom had setup an example of introduction and firm establishment of site-specific multidisciplinary teams and regular mandatory multidisciplinary meetings which are named as tumor boards in North America and also in most of the developing countries, like Pakistan.

In all fairness to our cancer patients, it will be a blessing for them if we spare time from our busy clinical commitments and devote it to organise these tumor boards for a thorough review and discussion of their cases. One may not be able to discuss all the cases in the early phase of inception of these boards; but, hopefully after going through the strengthening phase, selection criteria can be drawn to be adopted and implemented by the coordinator(s) of such boards.

Adding up ancillary services and allied healthcare groups in these boards would be considered as a secondary step. One can follow the example of multidisciplinary core membership from the lists given in United States-based National Comprehensive Cancer Network (NCCN) Guidelines. In our JCIA-accredited tertiary level healthcare related university, some site-specific multidisciplinary teams (MDT) have been formed which are conducting tumor boards on a regular basis covering site-specific areas like breast, head and neck, gynaecology, orthopaedics, neurology, gastro-enterology, urology, thyroid, and haematology. On the paediatric side, separate tumor boards are being conducted for paediatric solid tumors, haematological malignancies, and tumors of central nervous system. These boards attract participation from almost all institutions of the city. Paediatric boards are being conducted in joint collaboration with the Children Cancer Hospital; and for CNS tumors, the board is videolinked with Sick Kids Hospital, Toronto, Canada. Another

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Received: September 23, 2016; Accepted: October 07, 2016.

unique example is of City Tumor Board in Karachi which is a regular fortnightly event, regularly going on for the last 6 years. There are many relevant lessons which we can learn from our colleagues who have gone through the process of establishment of these boards. For example, studies are being conducted in the United Kingdom which are trying to explore the processes of decision-making employed in these multidisciplinary meetings.[1] MDT meetings have played an important role in increasing the number of case presentations at oncology conferences which reached to an all-time high. A study conducted at the Central DuPage Hospital, Winfield, USA, shows lung cases were presented at 149% of previous annual levels. Of the annual case load, 15% of the uterine cases were presented; before the advent of the multidisciplinary clinics, this rate was 0%.[2] MDT meetings have been shown to enhance graduate medical education by providing a unique experience not seen in the typical residency and fellowship training.[2] Patients identified by tumor boards are 2.5 times more, likely to be part of a clinical trial than other patients.[3]

As mentioned earlier, we are still trying to embrace the idea of development of this multidisciplinary culture in Pakistan. Personal attitudes play the most pivotal and strongest role in the establishment of these boards in academic institutes where specialists are practicing under one roof. As one can imagine, the task becomes more difficult in centres where comprehensive care is not available. Before the establishment of the earlier mentioned City Tumor Board, it was unimaginable for senior academic leads of different specialities to gather on Sunday mornings for even paid assignments. The success of this Board tells us a lot about selfless cancer carers who can devote their time even on a Sunday early morning for the sake of their cancer patients without thinking about any monetary or other gains. It would be a worthwhile reading for medical students and practicing clinicians to go through the updates on City Tumor Board.[4] In Pakistan, there are administrative and managerial gaps in healthcare services. In my humble opinion, instead of waiting for their correction and or wasting our valuable quality time in futile discussions, we can work together for the establishment of quality multidisciplinary teams. Weekly site-specific tumor boards can be achieved via these teams.

In the American Society of Clinical Oncology 2014 meeting, a commentary mentioned the role of tumor boards in service settings where resources are limited. Authors from Lebanon, Harvard (USA) and Sussex University (United Kingdom) suggested that tumor boards may help overcome these limitations. As Saghir *et al*. quoted, there are multiple benefits of these boards. A good number of treating clinicians put their trusts in decisions made by specialists teams at the tumor boards. These site-specific multidisciplinary boards are regarded by many doctors as a form of second opinion based on a team's efforts in which cases are being reviewed thoroughly and evidence-based recommendations are being made by consensus of experts.[5]

To summarise, MDT meetings play a very important role in better treatment of the cancer patients in significant number of cases at various tumor sites because members from different specialities augment each others' interpretations. The pathologist-radiologist correlation helps in better tumor staging, whereas surgeon-oncologist correlation results in improved treatment plan. Discussing increased number of cases with more attendance, improves the outcome of these meetings. It is, therefore, recommended that all tumor cases be discussed in MDT meetings regardless of site, staging and grading. It will also play a beneficial role in improving academics and research works. We are hoping to see establishment of multidisciplinary tumor boards in all institutes of Pakistan, where cancer care is being provided.[6] As the time is passing, more evidence is being gathered and published in contemporary literature supporting the need of site-specific tumor boards.[7]

A recently published systemic review clearly states the benefits of boards in terms of professional growth of healthcare providers.[8] In all the tertiary referral cancer institutions of Pakistan, early work of initiation of these site-specific multidisciplinary tumour boards is being started. Although the initiation phase seems to be progressing slowly, but we are witnessing a positive change of attitudes of treating physicians towards more patient-centred discussions among each other. In many high-volume institutes in Karachi, Lahore, Rawalpindi, Islamabad, Peshawar and Quetta, more and more site-specific boards are being conducted. In the peripheral cities of Pakistan, institutes are trying to establish these site-specific boards. In most of these centres in some form or other, general tumour boards are being conducted. We are spearheading this concept of developing MDT culture in the region, which will definitely improve our quality of healthcare.[9]

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