

The South West Clinical Senate met on 21st January 2016, Taunton Rugby Football Club.

The question:

It is recognised that currently in some circumstances, surgical treatments with limited benefit might be delivered to patients whereas there are greater limitations in the use of drug/medicine therapies.

With particular reference to patients thought to be in their final year of life, what guidance and information should be considered by MDTs when making decisions to undertake complex surgical procedures in order to assure that surgical interventions are in a patient's best interests?

Background to the Question

Multidisciplinary Teams (MDTs) in cancer surgery had identified a need for guidance regarding their work and boundaries if any when making recommendations to operate, particularly in the area of complex or highly invasive surgery where benefits may, in some cases, be limited.

The Clinical Senate Council met to review and advise on guidance to support decision making for surgery already commissioned, and did not seek to specifically comment on any one particular service. The question was brought by providers to Clinicians on the Senate Council with recognition that whilst there was no intention to limit surgical decision making, that there are natural benefits to both commissioners and the wider system in understanding and preventing unnecessary waste in treatment. The responsibility to arrive at a patient's ⁽¹⁾ best interests with decisions being made in the full awareness of an individual's life aspirations and circumstances also prompted the discussion.

Points of note that arose from Senate Council discussion;

- The Senate understands that the NHS spends in excess of 25% of its funds on care of people within their last year of life and estimates of 'last year of life' are notoriously difficult to predict accurately.
- In many cases, even where life expectancy is not anticipated to be increased, intervention is still justified for pain control or quality of life issues.
- There is concern that interventions with minimal expected extension to life but high risk of adverse effects of the intervention are being performed.
- The right decisions for MDTs are those that optimise quality of life, and may include avoiding poor quality of life, iatrogenic morbidity or extensive periods of patient time in high dependency situations.

- The General Medical Council does put a duty on doctors to consider resource usage, so abdication of responsibility for issues of wastage of NHS resource on unsubstantiated or dubious interventions is professionally unacceptable.
- There was also recognition that there was a duty to avoid waste and protect patients by ensuring that interventions with little or dubious benefit were not performed. MDTs appreciate that in areas such as drug/medicine therapeutics there are more rigorous frameworks for availability of treatments which are not necessarily applicable to surgery and queried whether cost-effectiveness should be part of their considerations. Currently where facilities and surgical expertise is available, it is at the discretion of the MDT as to what surgical procedures would be recommended to a patient.
- Although the recommendations focus on to cancer MDTs, which provided much of the evidence discussed by the Senate, are perhaps more clearly framed than in other areas of medicine, many of the principles can be extended to other MDT environments and apply more broadly, also being used to assist in the development of new MDTs.

There was unequivocal acknowledgement of the important role that an MDT plays with full agreement from the Senate Council that MDTs should be supported and developed.

Key roles of the MDT in Surgery;

1. To bring surgical decision-making and practice to within 95% confidence limits, ensuring uniformity of approach and good practice throughout.
 2. To provide a learning environment for consultants such that options proposed are tempered by an understanding of totality of risk and benefit, numbers needed to harm as well as numbers needed to treat and a realistic view as to what evidence truly supports a course of action. The Senate recognises that by nature of a surgeon's or oncologist's training there may be a bias towards overstating benefits regarding intervention; or understating dis-benefits; or uncertainty about the strength or acceptability of any non-surgical management options. Very often individual case recommendations have to be made only by extrapolation of an incomplete evidence base. Furthermore, as a generalisation, experience leads many clinicians to be less rather than more interventionist over time and this senior clinical support may be particularly valuable to newer Consultants.
- To provide an environment where sharing of pertinent information by expert members of the team tends to increase the mean performance of the whole.
1. To act as an expert technical reference group for surgeons and wider teams in appraising possible management options for a specific patient (given their particular functional and morbidity status) to then take to the patient for

subsequent decision making. Specifically, to begin, at the MDT, with the clinical appraisal of what could be done but to move to a position after proper informed patient discussion and consent is achieved to what should be done in the individual's circumstances. The Senate agrees there should be 'no decision about me without me' and the clinician-patient dialogue subsequent to and empowered by the MDT meeting is critical to this.

Recommendations of the South West Clinical Senate about surgical decision making at MDT

On MDT Functioning:

1. As well as its suggested options, a MDT should consider exit strategies for clinical cases where deterioration may raise the possibility of an expanding number of interventions perhaps close to the end of life. It should lead discussion on when it is no longer appropriate to continue to actively intervene which legitimately includes a cost-effectiveness consideration of 'wastefulness of NHS resources'. It should link with others and there should be clear allocation of responsibility for alternative care plans.
2. The Senate recognises the variability in breadth and complexity of different forms of MDT and the good work they do. It encourages MDTs' host organisations to facilitate peer review between similar types of MDT (site-specific for example) and recommends that occasional (at least bi-annual) cross-attendance of another Trust's comparable MDT should be standard practice to benchmark MDT performance with feedback of this learning to the originator MDT. We want to encourage consistency where appropriate and the sharing of ideas for best practice whenever possible.
3. There should be an annual case review of both random cases and others selected because they have posed challenging issues. Review of outcomes should not be limited to purely technical 1 month or 1 year survival but look too at patient reported outcome measures of quality of life such as, in retrospect would he / she make the same decision again.
4. It was noted that many cancer MDTs may process up to 50 cases in approximately two hours. Whilst many management options are clear cut and uncontroversial, others are difficult and nuanced. As well as the stated recommendation, there should be documentation of the main components that inform the recommended course of action (including non-surgical plans. This might be framed under palliative / intermediate / ambitious / aggressive with the top 2-3 reasons for the decision made. It should also document if recommendations are equivocal or contested. This would give an indicator of the health of their internal processes, and would support the annual case review being recommended by the Senate.

5. The Senate considered that there would be merit in a national register of cancer MDTs to support audit and improvement and benchmark case reviews nationally.
6. It is good practice for the MDT to crosscheck its behaviour against an ethical framework, such as those used by IFR panels. A recommended ethical framework is as follows; <http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2014/05/Thames-Valley-CCGs-Ethical-Framework-for-priority-setting-FINAL-2014.pdf.pdf> We should be just as willing to ask, “Why shouldn’t we operate?” as “Why should we?”
7. Trusts should ensure they assign high priority to the work of MDTs. There was general agreement that time for careful consideration would be likely to reduce questionable interventions and equip clinicians with better information for subsequent patient deliberations. There could be consideration of CQUINs attached to the function of MDTs.
8. Review and feedback of MDT involvement should contribute to clinicians' appraisal and revalidation.
9. It must be standard practice that someone at the MDT (‘key clinician’) has met the patient and knows him / her well enough to be able to describe their comorbidities and functional status so that management options that are realistic to that patient can be proposed. It would be more appropriate to think of a patient’s functional capacity and capability rather than pure ‘chronological’ age of a patient. (The key clinician is likely to be a cancer nurse specialist, but could on occasion be a surgeon, geriatrician, POPS member ⁽²⁾, GP or community matron as appropriate).

On Patient Involvement:

1. In options around cancer care, informed consent rarely takes place at a single point in time, but is a process allowing sufficient time for iterative reflection. Although acceptable timescales are rigorously defined, discussion should feel full and unhurried to allow ‘best interest’ decisions to be fully evaluated.
2. Options should not be portrayed as treatment versus no treatment. It is important to look at the risk/benefits for a particular intervention as opposed to the risk/benefits of another course of action that does not include that particular intervention. The patient needs to understand the management plan and possible scenarios for all options; interventionist and non-interventionist.
3. It follows that consultations leading to consent need a skilled clinically-intelligent communicator – the Senate encourages that individual MDTs identified a suitably skilled ‘key clinician’ who was the conduit for these discussions and who could act as a pivot between the patient or their advocates and the broader medical team. It is important that such a person can help patients understand their options and convey risk and uncertainty in a comprehensible way.

4. The 'key clinician' should have access to educational videos and other material explaining potential procedures and their implications to patients. These should include surgical and conservative approaches.

- Where the term 'patient' is used, it implies inclusion of either their family or another who is acting in an advocacy role for the patient'.
- POPS scheme as at <http://www.guysandstthomas.nhs.uk/our-services/ageing-and-health/specialties/pops/overview.aspx>