Decision by consensus: more political correctness or a genuine improvement in care?

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We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, he considers team working.

You will not need to be reminded that our summer months (such as they were) were witness to a wealth of sporting endeavours. In addition to the ubiquitous and oft-repeated terms like 'legacy', 'inspiration' and 'unbelievable', the word *team* also enjoyed a reasonable airing.

Extending the example of 'Team-*GB*', and employing a more cardiological perspective, I would submit the term 'Team *Heart*' for general consumption. Before readers assume that I am proposing a new Olympic competition in the form of the quickest call to balloon time, the largest number of new cardiac outpatients processed successfully in four hours, or the highest number of stents implanted during a 30-minute procedure, rest assured.

I am referring to the use of a multi-disciplinary team (MDT) approach in guiding the care of patients with heart disease. A recent national meeting in our own locality focused upon this topic, and I thought I would use this column to reflect some of the issues that were discussed.

How does it work and is it applied?

In the last year or two, international guidelines have advocated this approach supported more by a consensus of opinion than by any strong evidence base. There has been little provided in the way of examples or templates as to how such a collection of expertise is to be constructed, which cases are discussed and how a consensus is to be reached. How any recommendations are documented, whether they are executed or not and how reproducible the whole thing is, are further issues that most units could only dream of addressing – if indeed they were minded to in the first place.

A survey attempting to describe the national picture was reported and the results were certainly interesting. While many units have the semblance of an MDT process in place, the variation in frequency, timing and attendance is marked, as are the type of cases discussed. Often the session allocated is not within 'office hours' and nor is it a recognised part of an agreed consultant job plan. Perhaps predictably, direct *patient* involvement in these meetings is exceedingly rare.

Our own unit has embraced this concept for some years and was able to shed some light onto the actual outcomes of MDT discussions. Increasingly often, further investigation with a pressure wire is advised in order to clarify the functional significance of angiographically questionable disease. This not only assists any proposed angioplasty (PCI) but also helps our surgical colleagues plan their own operative procedures.

As for how often the MDT result is actually carried out as recommended, the answer is *most of the time*. Sometimes, when offered, the patient will decline surgery (CABG) or more rarely – and less easy to understand – PCI, and occasionally targeted vessels are managed differently, both by the surgeon and by the interventional cardiologist. Rarely, new or unrecognised comorbidity will have emerged prior to any recommended procedure, making one or other approach less attractive.

I have always wondered just how reproducible the process is, and we have been able to examine this as well. I am pleased to say that when cases were *re*-presented to the MDT (in a blinded fashion) the same decisions were reached in the majority. Those cases in which either further investigation or an alternative revascularisation modality was advised were those in which either PCI or CABG would have been acceptable reflecting the genuine equipoise that exists with many of the cases that we treat.

In that event the patient's own preference becomes particularly important but how that involvement is stage-managed is another topic of debate. Their presence during the MDT discussion itself can be distressing or intimidating – for both parties – and if the consensus view is to be presented subsequently, perhaps in an outpatient clinic, then thought might be given as to who actually does this.

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Is it valuable?

Most of the research around MDTs stems from cancer care where these are well established and found to be beneficial. Currently, evidence that they are of proven value in cardiology does not exist. However, as more cardiac units embrace the process there may well be an opportunity to look at and document outcomes before and after adopting this approach, and, thereby, build up an evidence base.

The psychology of team functioning is fascinating. There is always concern that the loudest voice or most senior figure will tend to influence the outcome. I can confirm that in our own experience, the latter is certainly not the case. Group dynamics will also come into play, with less confident individuals perhaps not feeling comfortable to express their views. Possibly, perverse decisions could result because smaller parties take refuge and confidence in the assumption that the larger group 'must surely know what it's doing'.

What – if any – are the medico legal implications of clinical management being derived by consensus? A common defence against alleged medical negligence is that a reasonable body of practitioners would have done the same thing – the application of the so-called *Bolam* test. A heart team might, therefore, be regarded as ideal in this regard in that it can effectively anticipate and supply the necessary rebuttal if called upon to do so in the future.

But, supposing a practitioner acts in a different manner to that recommended by an MDT, what might then be the consequences? I suppose that as long as the reasoning is justified and documented then it must surely be up to the man – or woman – on the spot to make decisions about a procedure for which they are directly responsible.

Expanding horizons

We know that other areas of cardiology are embracing this process. Transcatheter aortic valve implantation (TAVI) is one example, given the complex nature of the cases discussed, as well as the technology and expense involved. The hospital and community management of heart failure is another topic that has come under this umbrella, guiding the use of cardiac resynchronisation therapy (CRT), as well as instigating end-of-life pathways for less fortunate patients.

Another important area is infective endocarditis (IE). This is a fruitful hunting ground for the litigious type and a common source of negligence claims in cardiology. It involves a long hospital admission with the potential of many complications, patient care often handed over from team to team, and – sadly – a mortality rate that has altered little over the last few decades. As a result, some units discuss its current cases of IE at their regular MDT meetings. This ensures that all parties are up to date with recent clinical developments or test results, and an opportunity is not missed to adjust treatment or consider surgical intervention.

Additional extras

A frequently forgotten spin off from the MDT is recruitment into research trials and registries. As the proportion of a unit's elective activity declines, identifying cases suitable for inclusion into studies, with sufficient time in which to assess and enrol them, becomes more difficult. Exposure to a departmental meeting in which any treatment plans can be discussed then allows the possibility that these cases might also contribute to the hospital's research programme.

Given the variety of MDT meetings about, it is likely that some form of harmonisation will be devised so that all units more or less do the same thing. Patients will need to be involved, but at a stage when we are confident that our processes are robust. Rather than proscriptive, we should view this as reassuring; the actual outcome that derives as a consensus from discussion is not as important as the transparency of decision making

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