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EDITORIAL – GLOBAL HEALTH SERVICES RESEARCH

Multidisciplinary Care: How to Win Friends and Influence Your Colleagues to Provide Quality Goals-of-Care Discussions

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The acronyms are evocative from our colleagues in the SPRinT (Sarcoma, Peritoneal, and Rare Tumors) Department at the National Cancer Centre Singapore, creating the MD-PALS (multidisciplinary palliative surgical intervention) team; you almost get a sense that your "pals" are "sprinting" to come help you with your tough advanced cancer palliative surgical scenarios. In reality, these conversations are not enviable, and multidisciplinary resources routinely used for elective cancer care are not often dedicated to palliative surgical consultations. This is partly because these consultations often occur in the middle of the night with limited input from the primary medical oncologist and are inherently urgent. Nonetheless, palliative surgical consultations are frequent; palliative surgical procedures can account for more than 1,000 procedures per year at major cancer centers, 40% of all inpatient surgical consultations, and up to 25% of a surgical oncologist's practice.[1] Palliative surgeries also are also dangerous, with morbidity and mortality rates greatly exceeding elective cancer operations. Palliative surgical complications are among the worst complications presented at morbidity and mortality conferences and often are the most contentious. I am routinely surprised at the level of emotion and arguing that occur over advanced cancer clinical situations for which there is no surgical option to improve quality of life or offer durable palliation. Given these challenges, the article by Soon et al. is important in that represents one of the few studies evaluating a multidisciplinary approach to palliative surgical consultation and in doing so addresses a core discipline of surgical oncology.[2]

This pre-post interventional study evaluated the quality of goals-of-care (GOC) discussions by using a simple 4-point and 4-question score and identified a significant improvement in GOC discussion quality after the implementation of a multidisciplinary palliative surgery team.[2] This simple outcome measure reflects a considerable administrative and clinical effort in that all palliative surgical oncology cases were discussed and managed by the newly assembled MD-PALS team. The team included surgical, medical, and radiation oncology, palliative care physicians, gastroenterologists, interventional radiologists, advanced practice and specialty nurses, nutritionists, psychologists, and medical social workers. In addition to GOC, the authors identified increases in the quality of goals of surgery, prognosis, and code status. These gains are important but could underestimate the improvement in coordination of care. My personal experience is that patients and caregivers often are frustrated with the time to get input from all the disciplines included in the MD-PALS team. I applaud the group for their collaborative efforts. A meeting every 2 weeks may not be often enough, however, because palliative surgical consultations are a daily occurrence at many cancer centers.

There is room for improvement within this study, as only 42% of patients post-MD-PALS implementation received palliative care consultation, but also within our Society of Surgical Oncology, as there are no current requirements for palliative care rotations within the Complex General Surgical Oncology Fellowship. Recent studies have shown that palliative care consultation in the setting of malignant bowel obstruction can lead to wide interdisciplinary care and improved advanced cancer planning.[3] Studies also demonstrate individual preferences for communication frameworks, which can be important in GOC discussions.[4] As a society, we should better train our surgical

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oncologists in communication strategies to improve patient understanding of prognosis and create realistic expectations for outcomes to obtain the best goal-concordant decision for each patient and family.

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