Survey on status of MDT conferences in DMCG.dk

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DANSKE MULTIDISCIPLINÆRE CANCER GRUPPER DMCG.dk

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Background

The MDT Committee was established by the Executive Committee of the Danish Multidisciplinary Cancer Group (DMCG.dk) in 2015. Based on a demand from Danish Regions, The Danish Clinical Quality Program – National Clinical Registries (RKKP), DMCG.dk and the Danish Health Authority for clinically entrenched guidance, the Committee prepared a guide for conducting MDT conferences.

Since 2015, the implementation of an optimal framework has become the focus of the committee's work, first with a survey report in 2019 and then with this survey for the Chairmen and the MDT Conferences within all DMCGs. DMCG.dk wishes to follow up on the implementation and development of MDT conferences and identify any needs for adjustment of the current guidelineance.

The present study is based on two questionnaire surveys; one aimed at the Chairmen of cancer groups, and the other aimed at the individual MDT conferences. The former has primarily focused on the role of the MDT conference in the clinical guideline of the specific DMCG, while the latter has primarily focused on the practical work of the MDT conferences. The content of the questionnaires has been discussed and evaluated in the MDT Committee as well as in the Common Indicators Committee. We are grateful for all the constructive input we have received.

It has been possible to fill in the questionnaires both electronically and in writing by mail.

Distribution of the questionnaires to Chairmen of all cancer groups in DMCG.dk was managed by Dorrit Andersen, RKKP. Surveys were forwarded on 25 May 2021 and deadline for responding was 1 July 2021. The Chairmen have also sent questionnaires to the MDT conferences within their own cancer groups across the country.

The Survey of Chairmen has been forwarded to 25 Chairmen and we have received 15 responses. The survey targeting individual MDT conferences has generated 57 responses. Results of both surveys are included in this report.

It is our hope that the responses will lead to reflections and debate.

On behalf of the MDT Committee

Torben Riis Rasmussen

Chairman of the MDT Committee,
Consultant, Clinical Associate Professor

Overall assessment of the status of MDT conferences based on this survey

It should be noted that a few DMCGs have defined in their guidelines how an MDT Conference should be conducted within their cancer group. A few have indicated in their guidelines which issues should be clarified at the MDT Conference or which information should be available before the patient is discussed at the MDT Conference. In the guidelines of the majority of the DMCGs it is not made clear how the patient's possible somatic or psycho-social comorbidities should be included in the decisions at the MDT Conference. However, more than half of the MDT Conferences state that patients' preferences are fully or partially included in the discussion, and in just above half of the MDT Conferences it is also stated that the MDT Conference includes an overall written presentation of the results of the patient's diagnostic work-up – a recommendation from the previous survey of the MDT Committee. However, less than half of MDT conferences document the conference decision at the conference; similarly, less than half of MDT Conferences ensure that the note on the decision is a correct representation of the MDT decision.

At present, only a few of the DMCG Chairmen report that their DMCG has started to systematically record whether their patients have been discussed at an MDT Conference, which in the future has been chosen as a common quality indicator for all cancer pathways. However, the responses of the MDT participants show that about two-thirds of all patients in cancer pathways are discussed at MDT Conferences, and almost half of the MDT Conferences indicate that they register that an MDT conference has been held either directly in their database or with a code in the National Patient Register. The patients who are not discussed at an MDT Conference are patients who are perceived as either clearly incurable or patients who are considered clearly curable. However, some patients fall outside these two categories, but the present survey cannot precisely identify which patients. It could be speculated if the diagnostic work-up has not detected any malignancy in these patients which is then concluded at an MDT Conference.

Compared to the results of the MDT Committee's earlier survey on the MDT conferences within the four largest cancer groups – breast, lung, prostate, and colorectal cancers – it seems that conditions have improved at most MDT conferences compared to earlier now indicating the majority to have satisfactory locations and available electronic equipment. As recommended in the previous MDT Committee survey, there is now to a large degree a clear ownership of location and equipment. It seems that there is now generally the time needed for the actual organization of the MDT Conference, which was also recommended in the previous survey. However, the necessary time to prepare MDT conferences is still insufficient, which affects particularly radiologists and pathologists, who represent the two specialties most frequently participating in the MDT conferences. Moreover, there is substantial variation in whether follow-up on decisions from the MDT Conference are integrated into how the clinical work is organised.

In a few cancer groups, internal audits are held on MDT decisions in relation to whether the treatment decisions at the MDT Conference correspond to best practice/are in accordance with the most recent guideline; external audits to a large extent do not occur. In several cancer groups, however, national MDT Conferences are held.

Site visits for inspiration and learning from other MDT Conferences are rare.

The educational potential of MDT Conferences is not being fully exploited, with fewer than half of MDT Conferences planning for attendance of junior doctors.

Overall, it can be concluded that in several of the areas where recommendations were made in the previous survey of the MDT Committee, improvements have been made in line with the recommendations. This applies to the unambiguous ownership of conference facilities in the form of location and electronic equipment and the functioning of the equipment. Also, partly in terms of the allocated time needed before, during and after the MDT Conference.

Concerning other recommendations, there is still a potential for development. The educational potential is not fully exploited, and in only about half of the MDT Conferences, findings from patients' diagnostic work-up are presented in a comprehensive written presentation, and fewer than half of the MDT Conferences ensure that the note regarding the decision from the conference is in line with the decisions made at the conference.

Only two-thirds of patients are discussed at a MDT Conference, although in principle it is recommended to discuss all patients. When this is introduced as a common quality indicator, a standard of 90% is likely to be set. However, it is also a challenge for many cancer groups with a large patient volume to discuss all patients at an MDT Conference. One solution to this dilemma could be a guideline defining which patients could be discussed at an MDT Conference in a fast-track system, as it is known from some places abroad (including Basel/Switzerland), where a proposal for a decision regarding a patient can be issued electronically in certain specific patient categories. If all specialties involved in the MDT Conference agree to the proposal submitted, it will thus be adopted as an MDT conclusion. If just one disagrees to the proposed decision for the patient, then the patient must be evaluated at a regular MDT conference. This approach would reduce the volume of patients to be discussed at the regular MDT conferences. Moreover, patients can be MDT conferenced on a daily basis and do not have to wait until the next ordinary MDT Conference.

Unfortunately, there is still a long way to go in relation to the development potentials identified by the previous MDT Committee survey, which primarily concerned monitoring and ensuring the quality of decisions at the MDT Conference.

The quality development potentials listed in the conclusion of the MDT Committee's earlier survey are outlined below, and they are to a large extent still valid.

- That national conferences are set up regarding the development of form and exchange of experiences concerning the concept of MDT conferences, partially funded by DCCC.
- Establishing national conferences to obtain national consensus.
- That national audits are organized for patient cases in specific disease areas.
- An organization is established in the DMCG (possibly the MDT Committee) which conducts site visits to exchange experiences and develop MDT Conferences.
- Research is conducted within the MDT area, including the inclusion of the patient perspective.
- That practice experience with MDT work is exchanged and developed to increase the quality, improve professional treatment options, etc.

A quality development potential could also be to conduct a post-therapeutic MDT conference to strengthen learning by updating MDT Conference participants on whether the decision on treatment led to the intended outcome. A single MDT site within DBCG (at OUH) reports practicing this approach, which is also known from abroad.

MDT Survey – DMCG Chairmen

A survey has been forwarded to 25 DMCG Chairmen and 15 responses have been received. The available responses do not provide an overview of all the current MDT Conferences under the auspices of DMCG.

Q1 Name of DMCG Group and Q2: At which hospitals are MDT conferences held within your DMCG?

Answer No 1	**Q1 Group Name**	**At which hospitals are MDT conferences held within your DMCG?**
1	PAL (*Danish Multidisciplinary Cancer Group for Palliative Action*)	-
2	DSG (*Danish Sarcoma Group*)	Rigshospitalet (including participation from Herlev Hospital), Aarhus University Hospital
3	DLG (*Danish Lymphoma Group)*	Rigshospitalet, (Herlev Hospital until recently), Zealand University Hospital Roskilde, Vejle Hospital, Odense University Hospital, Aarhus University Hospital, Aalborg University Hospital, Holstebro Regional Hospital, Esbjerg Hospital
4	DSKMS (*Danish Study Group for Chronic Myeloid Diseases*)	-
5	DBCG (*Danish Breast Cancer Group*)	Aalborg University Hospital, Aarhus University Hospital, Viborg Hospital, Vejle Hospital, Esbjerg Hospital, Aabenraa Hospital, Odense University Hospital, Herlev Hospital, Rigshospitalet, Zealand University Hospital Roskilde
6	DPCG (*Danish Pancreatic Cancer Group*)	Odense University Hospital, Aarhus University Hospital, Aalborg University Hospital, Vejle Hospital, Rigshospitalet
7	ALG (*Acute Leukaemia Group)*	Aalborg University Hospital, Aarhus University Hospital, Odense University Hospital, Zealand University Hospital Roskilde, Herlev Hospital/Rigshospitalet
8	DOOG (*Danish Ocular Oncology Group*)	Rigshospitalet, Aarhus University Hospital
9	DLCG (*Danish Lung Cancer Group*)	Aalborg University Hospital, Aarhus University Hospital, Vejle Hospital, Odense University Hospital, Zealand University Hospital Roskilde, Næstved Hospital, Gentofte Hospital, Bispebjerg Hospital
10	DCCG (*Danish Colorectal Cancer Group*)	Colon cancer: Bispebjerg Hospital, Herlev Hospital, Hillerød Hospital, Hvidovre Hospital, Rigshospitalet, Zealand University Hospital Roskilde, Slagelse Hospital, Hospital Lillebaelt, Odense University Hospital, Southwest Jutland Hospital, Sønderjylland Hospital, Aarhus University Hospital, Horsens Hospital, Regional Hospital West Jutland, Randers Regional Hospital, Viborg Regional Hospital, Aalborg University Hospital, North Denmark Regional Hospital. Rectal cancer: Bispebjerg Hospital, Herlev Hospital, Hillerød Hospital, Hvidovre Hospital, Zealand University Hospital

		Roskilde, Slagelse Hospital, Lillebælt Hospital, Odense University Hospital, Southwest Jutland Hospital, South Jutland Hospital, Aarhus University Hospital, Regional Hospital West Jutland Aalborg University Hospital
11	DGCG (*Danish Gynaecological Cancer Group*)	Aalborg University Hospital, Aarhus University Hospital, Odense University Hospital, Herlev Hospital, Rigshospitalet
12	DaBlaCa (*Danish Bladder Cancer Group*)	Aalborg University Hospital, Holstebro Regional Hospital, Aarhus University Hospital, Odense University Hospital, Herlev Hospital, Zealand University Hospital Roskilde and Rigshospitalet
13	DaPeCa (*Danish Penis Cancer Group*)	Aarhus University Hospital, Rigshospitalet
14	DAHANCA (*Danish Head & Neck Cancer Group*)	Rigshospitalet, Herlev Hospital, Aalborg University Hospital, Aarhus University Hospital, Odense University Hospital
15	DNOG (*Danish Neuro-Oncology Group*)	Rigshospitalet, Aalborg University Hospital, Aarhus University Hospital, Odense University Hospital

We have not received responses from:

DACG (*Danish Anal Cancer Group*),
DMG (*Dansk Melanoma Group*),
DAPHO (*Danish Paediatric Haematological* Group),
DHG *(Danish Multidisciplinary Non-Melanoma Skin Cancer Group),*
DAPROCA (*Danish Prostate Cancer Group*),
DARENCA (*Danish Renal Cancer Group*),
DATECA (*Danish Testis Cancer Group*),
DEGC *(Danish Esophagogastric Cancer Group*),
DLGCG (*Danish Liver-Bile Road Cancer Group*),
DMSG (*Danish Myelomatosis Study Group*).

PAL do not have their own conferences or attend MDT conferences.

Q3: Does the DMCG have guidelines on how to conduct an MDT Conference (e.g., requirements for the participation of specific specialties for decision-making or presentation design)?

Options	%	Responses
Yes	6.7 %	1
No	60.0%	9
Partly	33.3%	5
Total		15

Specification of which specialties should have mandatory representation does not appear to be widespread. Although the Danish Health Authority has the MDT Conference as a marker of the course of events, they have not specified this.
The Danish Health Authority simply states that the patient must be assessed at the MDT Conference and when.

Q4: Is discussion at the MDT Conference systematically recorded in the database and/or in the National Patient Register with a PPS code?

Options	%	Responses
Yes	20%	3
No	80%	12
Do not know	0%	0
Total		15

As only three out of fifteen have responded to this question in the affirmative. Thus, the need to focus on registration is confirmed. Recording of discussions at the MDT Conference is a quality indicator aim.
It is not clear whether the answer covers national or is locally based.

Q5: If so, is it then published e.g., as an indicator in the annual report?

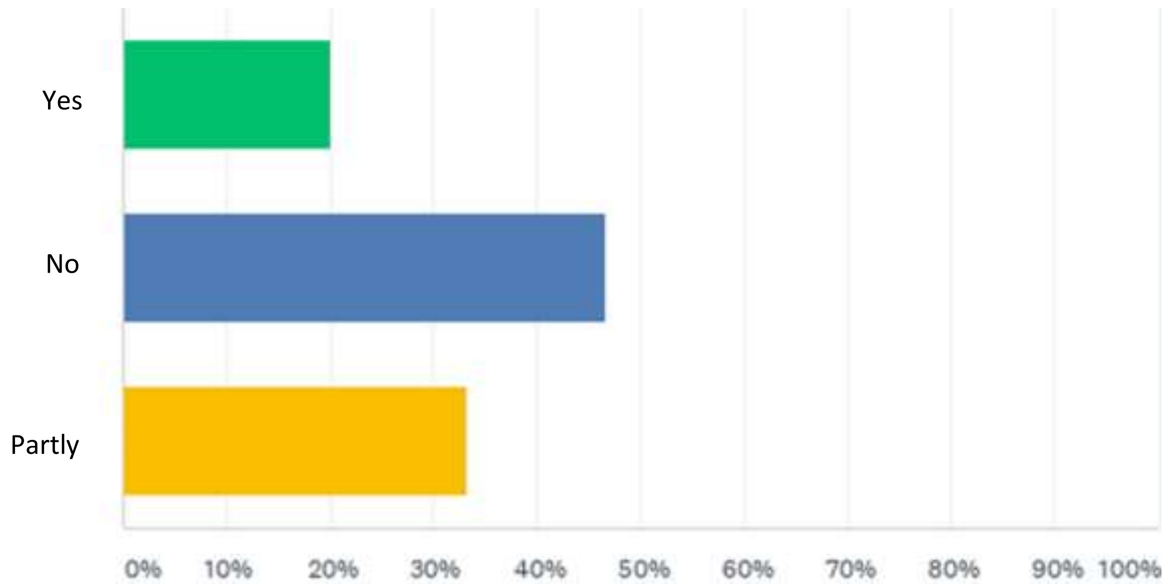
Options	%	Responses
Yes	66.7 %	2
No	33.3%	1
Total		3

The question has only been completed by the three who replied in the affirmative to Question 4.

One might consider whether the issue is misunderstood, and the annual report is associated with the cancer group's annual report to the RKKP rather than the annual report of the database.

In future surveys it should be specified that the question is regarding the annual report of the database.

Q6: Does the guideline set out criteria for which patients to discuss at the MDT Conference?



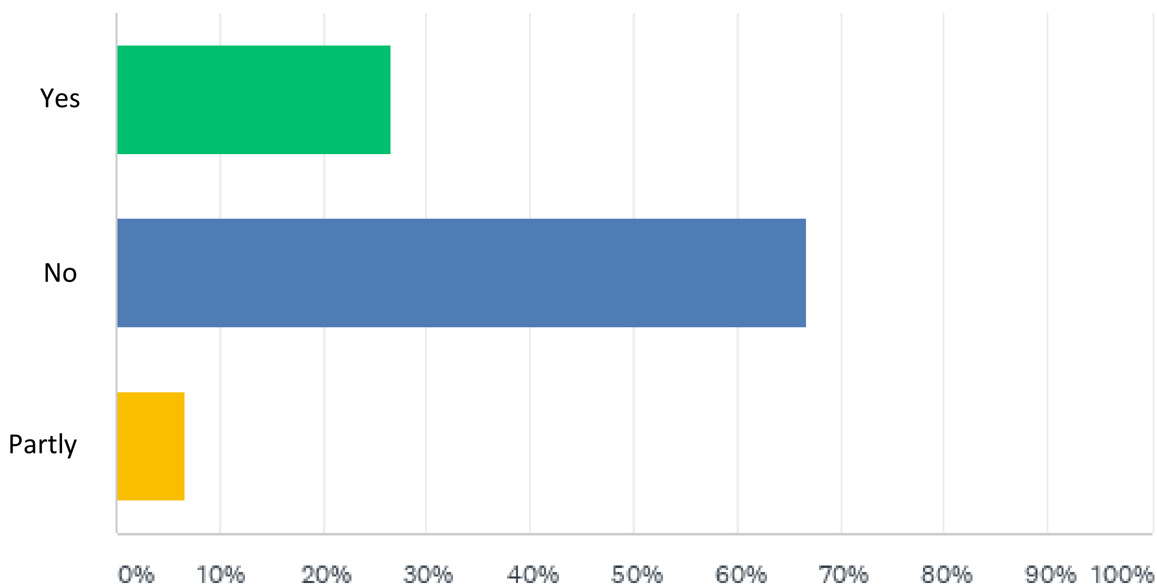
Options	%	Responses
Yes	**20.0 %**	**3**
No	**46.7%**	**7**
Partly	**33.3%**	**5**
Total		**15**

In terms of quality, it should be defined which patients should be discussed and which exceptions to be made.

Some MDT conferences only enrol newly identified patients, and some do not have the ability to register recurrences in the database.

To establish an indicator of registration, it must be very precise which visit or discussion to report. For many conferences, the first discussion at the conference will be the most accurate.

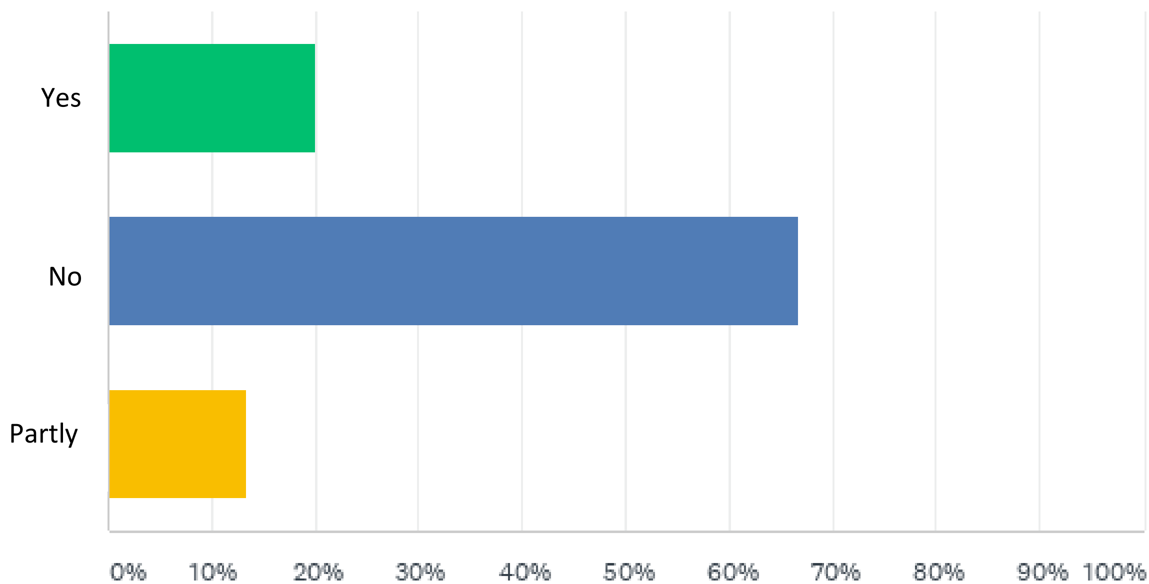
Q7: Does the guideline specify which information should be available before the MDT Conference?



Options	%	Responses
Yes	26.7 %	4
No	66.7%	10
Partly	6.7%	1
Total		15

The amount of available information on the case before discussion at the MDT conference varies. Very few conferences seem to have this specified in a guideline. There is a need for continuous updating of specifications, but as described in the guideline on the organisation of MDT conferences, this is indisputably very relevant. It often delays the patient's diagnostic workup when information is missing.

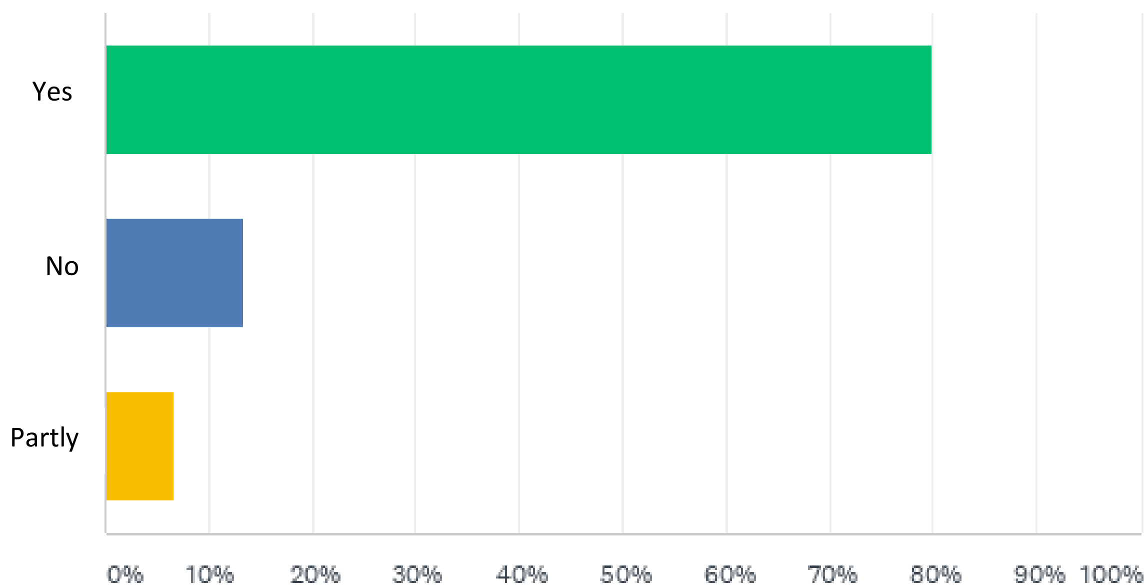
Q8: Does the guideline specify which clinical issues need to be clarified at the MDT Conference (e.g., TNM stage or possible treatments)?



Options	%	Responses
Yes	20.0%	3
No	66.7%	10
Partly	13.3%	2
Total		15

A fifth of the guidelines have specified the clinical issues to be clarified at the MDT Conference, while two-thirds have not. The responses are linked to the limited number of people who responded positively to the availability of a guideline.

Q9: Do the DMCG clinical guidelines indicate which treatment to offer a specifically defined patient?



Options	%	Responses
Yes	**80.0%**	**12**
No	**13.3%**	**2**
Partly	**6.7%**	**1**
Total		**15**

It seems surprising that three cancer groups have no guidelines on this.

This may be explained by some groups not having MDT conferences or clinical guidelines, e.g., PAL.

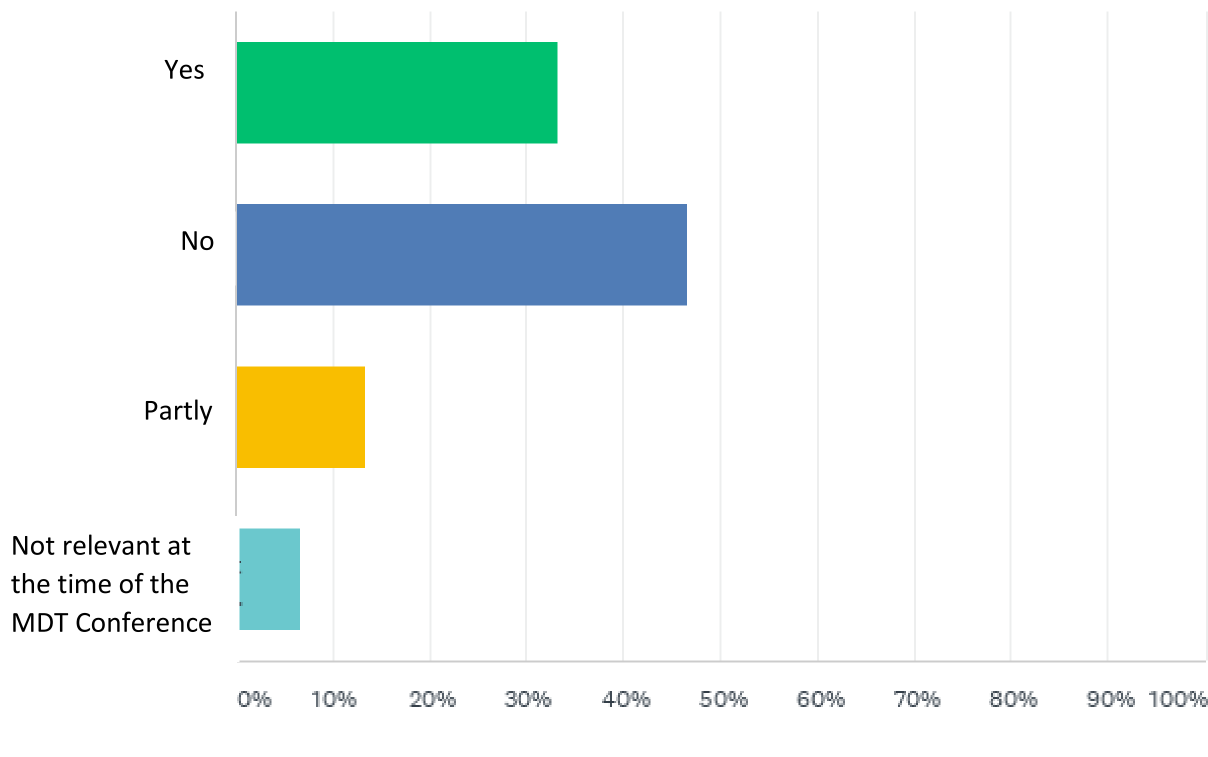
Q10: Deleted in the context of subsequent review of responses.

Q11: Does the guideline specify that patients should be informed of the possibility of a second opinion at another MDT Conference?

Options	%	Responses
Yes	**0%**	**0**
No	**100%**	**15**
Total		**15**

It is debatable where such a rule about informing the patient belongs - in a guideline or more under the general auspices of the National Board of Health?

Q12: Does the clinical guideline of the cancer group specify that the patient's possible somatic comorbidities should be assessed/included at the MDT Conference?

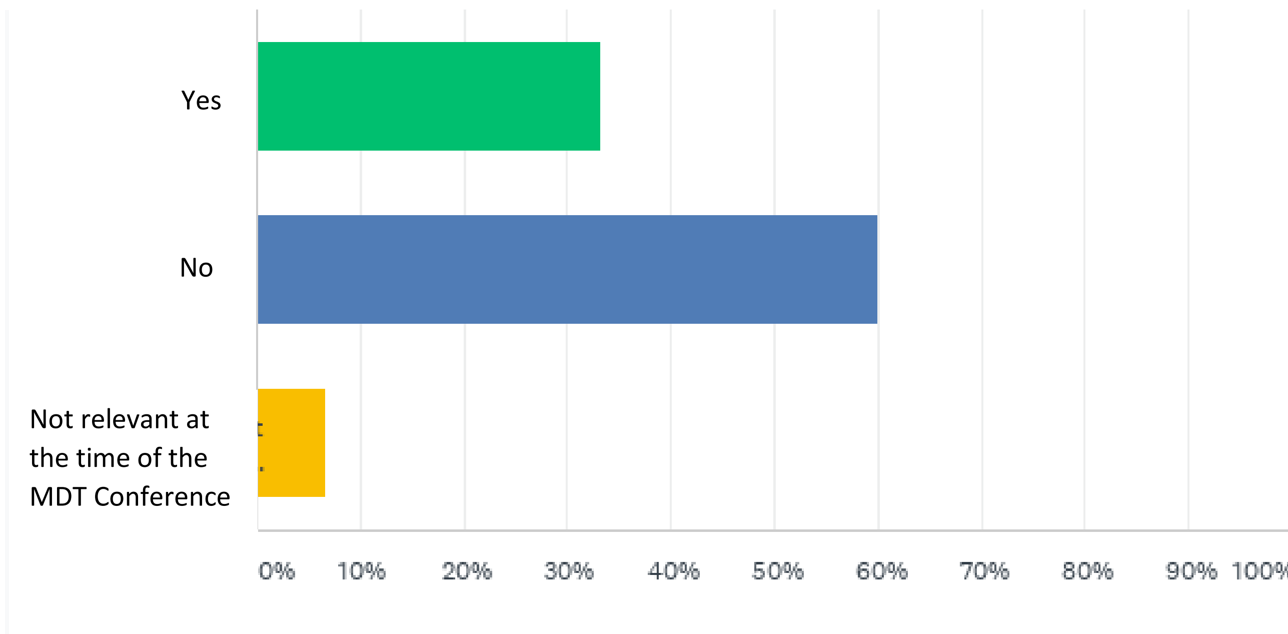


Options	%	Responses
Yes	**33.3%**	**5**
No	**46.7%**	**7**
Partly	**13.3%**	**2**
Not relevant at the time of the MDT conference	**6.7%**	**1**
Total		**15**

Although not explicitly stated, many consider that this is done at the conference.

Obviously, it is beneficial to have something in writing and to include it at the MDT conference, but it is not always possible. The answer 'Not applicable' may therefore in some cases actually be 'Not possible'.

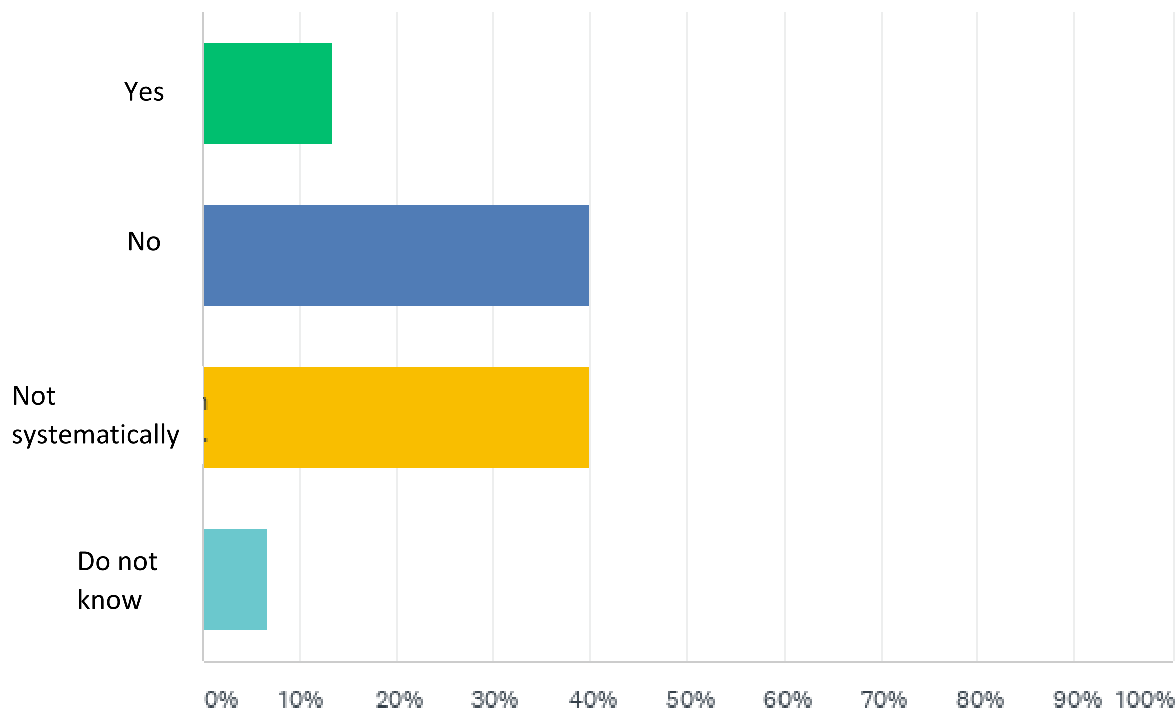
Q13: Does the guideline indicate that the patient's possible psychosocial, supportive & palliative care needs should be considered in relation to the MDT Conference decision?



Options	%	Responses
Yes	33.3%	5
No	60.0%	9
Not relevant at the time of the MDT conference	6.7%	1
Total		15

The question relates to previous issues. Questions and answers only say something about whether it is specified; in 60% this is currently not the case.

Q14: Within the DMCG there is a tradition for an internal (in its own MDT context) audit to verify that the treatment decisions at the MDT Conference correspond to best practice / are in accordance with updated clinical guidelines?



Options	%	Responses
Yes	13.3%	2
No	40.0%	6
Not as a systematically planned activity	40.0%	6
Do not know	6.7%	1
Total		15

The answers are based on national traditions in the respective cancer groups, i.e., the extent to which cancer groups ensure that such measures are implemented in the individual MDT conferences.

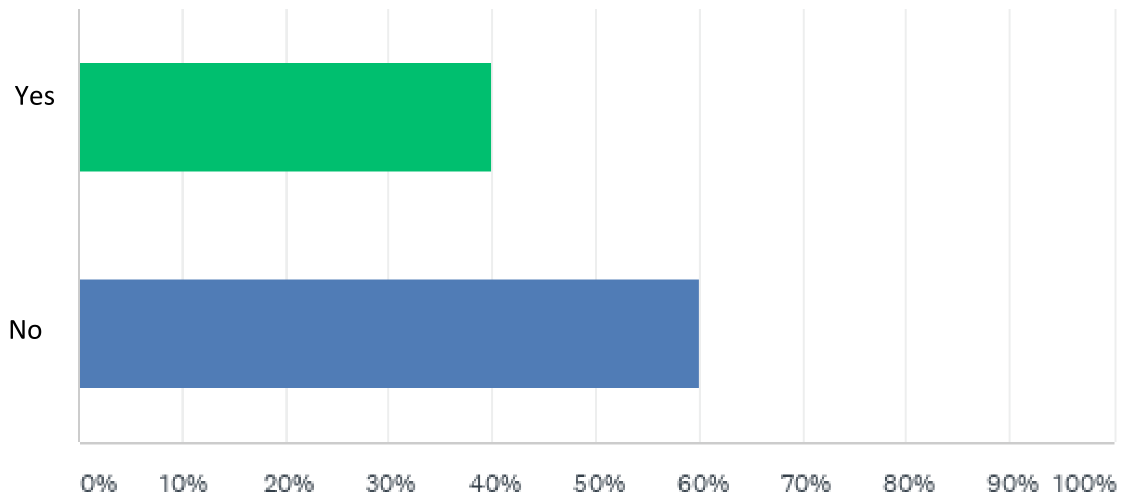
Only two out of fifteen have a tradition for internal auditing of MDT decisions.
Responses must be compared with responses from the local MDT Conference.

Q15: Is there an agreement within the DMCG that external audits are carried out to verify that treatment decisions at MDT Conference correspond to best practice / are in accordance with updated clinical guidelines – e.g., by allowing other MDT conferences within the same DMCG cancer package to reassess a sample of cases without knowledge of the previous MDT's assessment and decision in relation to diagnosis, TNM categories, UICC etc. stage and treatment provision?

Options	%	Responses
Yes	0%	0
No	100%	15
Not as a systematically planned activity	0%	0
Do not know	0%	0
Total		15

Responses must be compared with responses from the local MDT Conference.

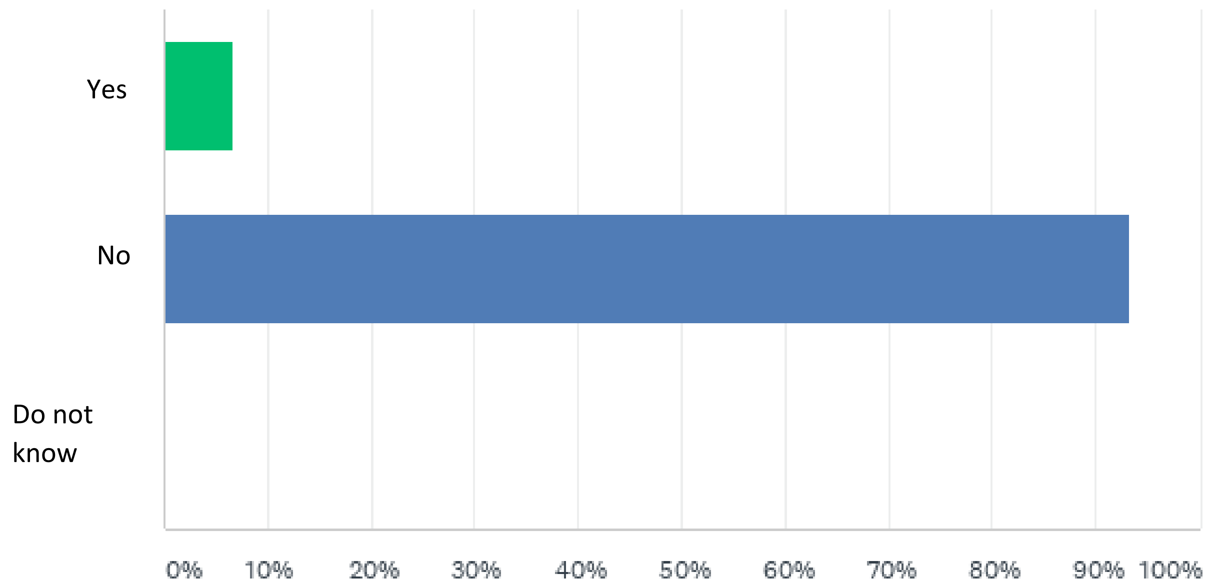
Q16: Are National MDT conferences held within the DMCG?



Options	%	Responses
Yes	40%	6
No	60%	9
Total		15

Since the number of MDT conferences in each cancer group varies as does the number of cases, this should be considered when interpreting these responses.

Q17: Is there a tradition within the DMCG for site visits at other MDT conferences for the purpose of exchanging experiences?



Options	%	Responses
Yes	6.7%	1
No	93.3%	14
Do not know	0.0%	0
Total		15

The responses show that such an initiative is difficult to organize within the daily clinical work.
Site visits could make perfect sense if it was possible to organize and prioritize.
Responses must be compared with responses from the local MDT Conference.

Summary of results based on the responses from DMCG Chairmen

In conclusion,

- very few DMCGs have a guideline for the MDT Conference
- discussion of patients at an MDT Conference is in 80% of the DMCGs not systematically recorded in the database and/or in the National Patient Register
- very few groups have clinical guidelines indicating which clinical issues need to be clarified at the MDT Conference (such as TNM stage and treatment options). Most of the guidelines describe which treatment options patients should be offered
- nearly half of the groups have not specified in the clinical guidelines which patients should be assessed at the MDT Conference
- two thirds do not have a guideline outlining which information about the patient should be available prior to the conference or which issues should be clarified at the conference
- most groups do not have a guideline indicating that the patient's possible somatic comorbidities should be assessed at the MDT Conference
- sixty percent of the groups indicate that no guideline states that the patient's possible psychosocial, supportive, and palliative care needs should be considered in relation to the MDT Conference decision
- no DMCG group has a guideline stating that the patient should be informed about the possibility of a second opinion
- internal audits of MDT decisions take place to some extent while external audits do not
- national conferences take place in some cancer groups while site visits are rare.

MDT Conference status - survey of participants/MDT conferences

Q1: DMCG Cancer Group and 2: Hospital:

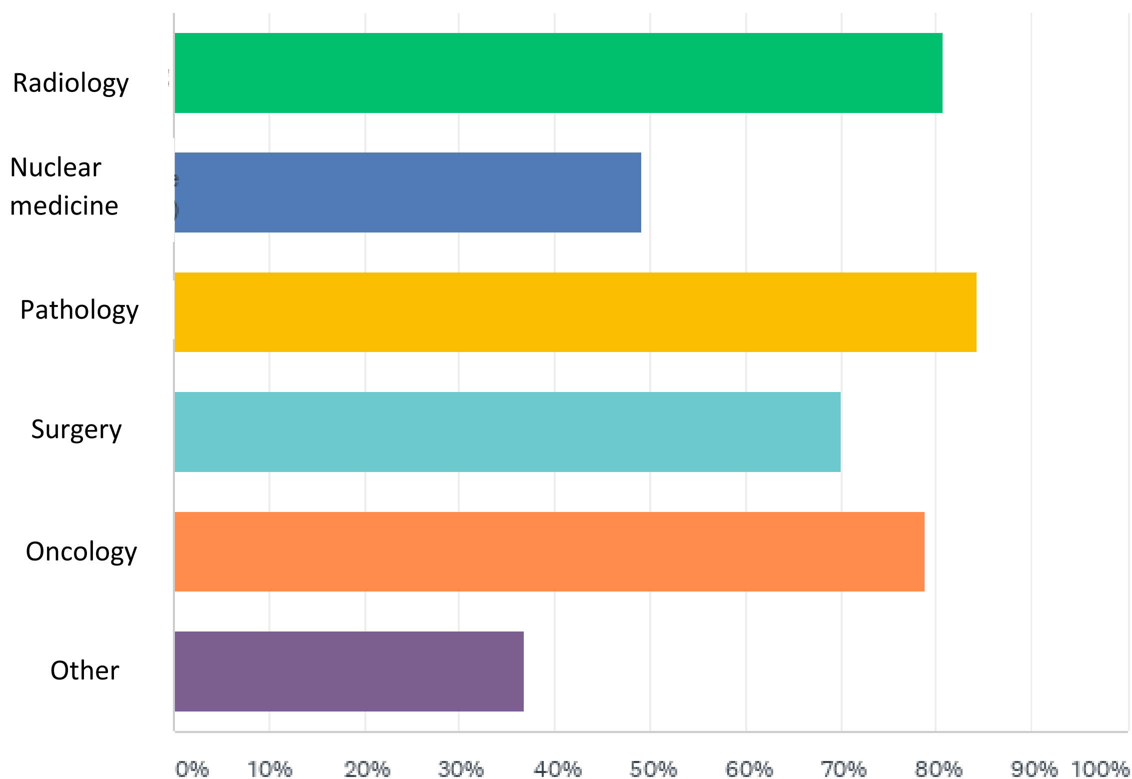
Answer Number	Cancer group	Hospital
1	Haem-DMCG, Acute Leukaemia	Aalborg University Hospital
2	Haem	Rigshospitalet
3	DLCG	Næstved Hospital (Næstved-Slagelse-Ringsted Hospital)
4	DLCG	Aarhus University Hospital
5	DLCG	Bispebjerg Hospital
6	DLCG	Bispebjerg-Frederiksberg
7	DLCG	Odense University Hospital, OUH Centre for Lung Cancer (CFL)
8	DGCG	Odense University Hospital
9	DGCG	Aarhus University Hospital
10	DGCG	Aalborg University Hospital
11	DaBlaCa	Aarhus University Hospital and Holstebro Regional Hospital (joint regional MDT)
12	DaBlaCa	Herlev Hospital
13	DaBlaCa	Aalborg University Hospital
14	DaBlaCa	Zealand University Hospital Roskilde
15	DaBlaCa	Odense University Hospital
16	DaBlaCa	Rigshospitalet
17	DAHANCA	Aarhus University Hospital
18	DAHANCA	Rigshospitalet/Herlev Hospital
19	DAHANCA	Aarhus University Hospital
20	DAHANCA	Aalborg University Hospital
21	DaProCa	Herlev Hospital
22	DOOG	Rigshospitalet
23	ALG	Aarhus University Hospital
24	ALG	Odense University Hospital
25	ALG	Herlev Hospital
26	DBCG	Aarhus University Hospital
27	DBCG	Rigshospitalet
28	DBCG	Herlev Hospital and Rigshospitalet, 50% at each
29	DBCG	Aalborg University Hospital
30	DBCG	Hospital South Jutland, Aabenraa
31	DBCG	Herlev - Gentofte Hospital
32	DBCG	Roskilde/Næstved
33	DBCG (NOTE: we have both an ordinary and a post-treatment MDT)	Odense University Hospital

34	DBCG	Zealand Hospital, Roskilde
35	DBCG	Lillebælt Hospital, Vejle
36	DBCG	Herlev Hospital (oncology patients who have completed further course)
37	DBCG	Herlev Hospital (neoadjuvant treatment with regard to preoperative assessment)
38	DSKMS - Chronic myeloid	Zealand University Hospital Roskilde
39	DSKMS - Chronic myeloid	Rigshospitalet
40	DSKMS - Chronic myeloid	Aalborg University Hospital
41	DPCG	Rigshospitalet
42	DLG - Danish Lymphoma Group	Aalborg University Hospital
43	DLG - Danish Lymphoma Group	Herlev Hospital
44	DLG - Danish Lymphoma Group	Aarhus University Hospital
45	DLG - Danish Lymphoma Group	Holstebro Regional Hospital
46	DNOG	Aalborg University Hospital
47	DCCG	Odense University Hospital /Svendborg Hospital
48	DCCG	Aalborg University Hospital
49	DCCG	Zealand University Hospital Slagelse
50	DCCG	Randers Regional Hospital
51	DCCG	Hvidovre Hospital
52	DCCG	South West Jutland Hospital
53	DCCG	Viborg Hospital
54	DCCG (CRC-MDT SUH)	Zealand University Hospital Køge
55	DCCG (Rectum, includes colorectal, advanced, sarcoma, etc.)	Aarhus University Hospital
56	Danish Sarcoma Group (DSG)	Rigshospitalet
57	-	Zealand University Hospital Roskilde

Q3: Which specialty is primarily responsible for the investigation and presentation at the MDT Conference?

The breakdown of responses is as follows:	
Mamma surgery:	8
Radiology:	2
Surgery:	10
Haematology:	11
Surgery (ordinary)/Oncology (post MDT):	1
Ear-Nose-Throat Surgery:	4
Pulmonary medicine:	5
Orthopaedic surgery:	1
Urology/Oncology:	1
Gastrointestinal surgery:	1
Pathology:	2
Neurosurgery:	1
Ophthalmology:	1
Gynaecology:	3
Urology:	6
TOTAL:	**57**

Q4: Mandatory specialty participants?



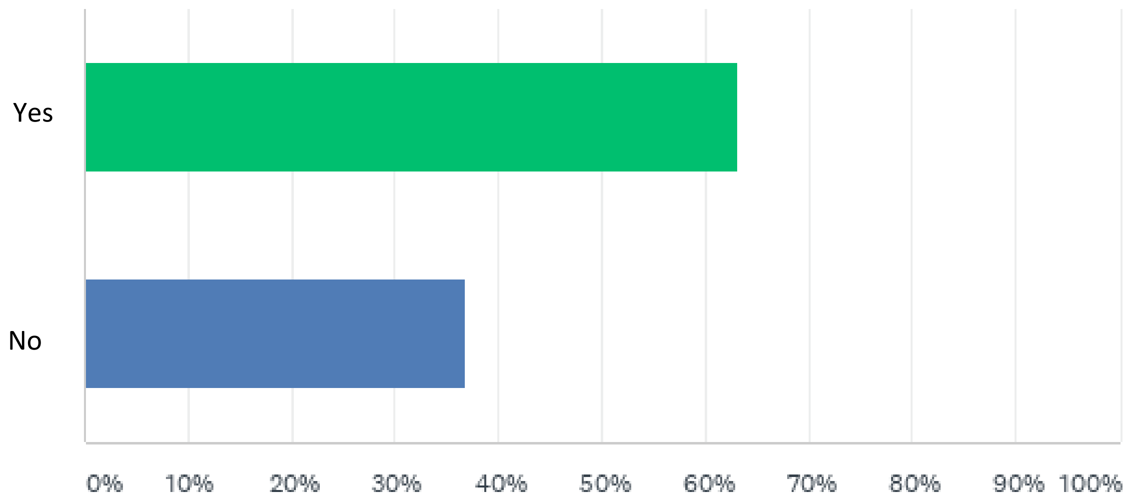
Options	%	Responses
Radiology	80.7%	46
Nuclear Medicine (PET)	49.1%	28
Pathology	84.2%	48
Surgery	70.2%	40
Oncology	79.0%	45
Other	36.8%	21

'Other' includes nurse coordinator and secretary.

There seems to be a relatively broad, fixed membership at MDT conferences. Whether it is perceived that there is a lack of specialties or competences represented has not been investigated.

It is relatively surprising that PET/CT is not represented more frequently.

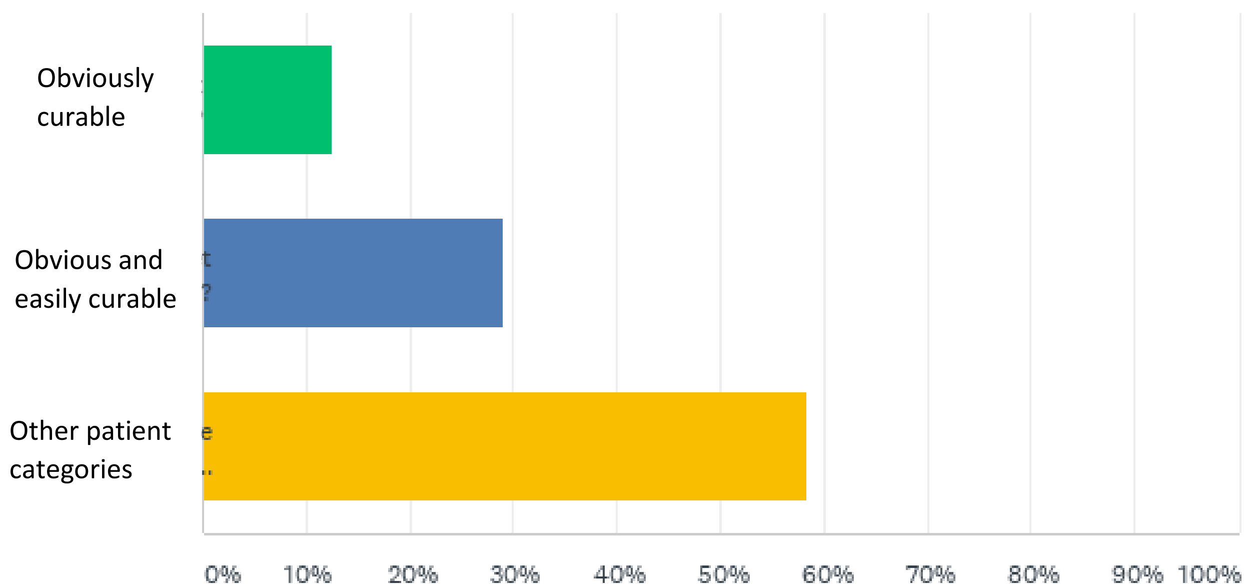
Q5: Are all patients in the DMCG cancer package pathways discussed at the MDT Conference?



Options	%	Responses
Yes	63.2%	36
No	36.8%	21
Total		57

Reasons why more than a third of patients in cancer package pathways are not discussed at a MDT Conference are elaborated in Q6.

Q6: If not, which patient are not be discussed at the MDT Conference?



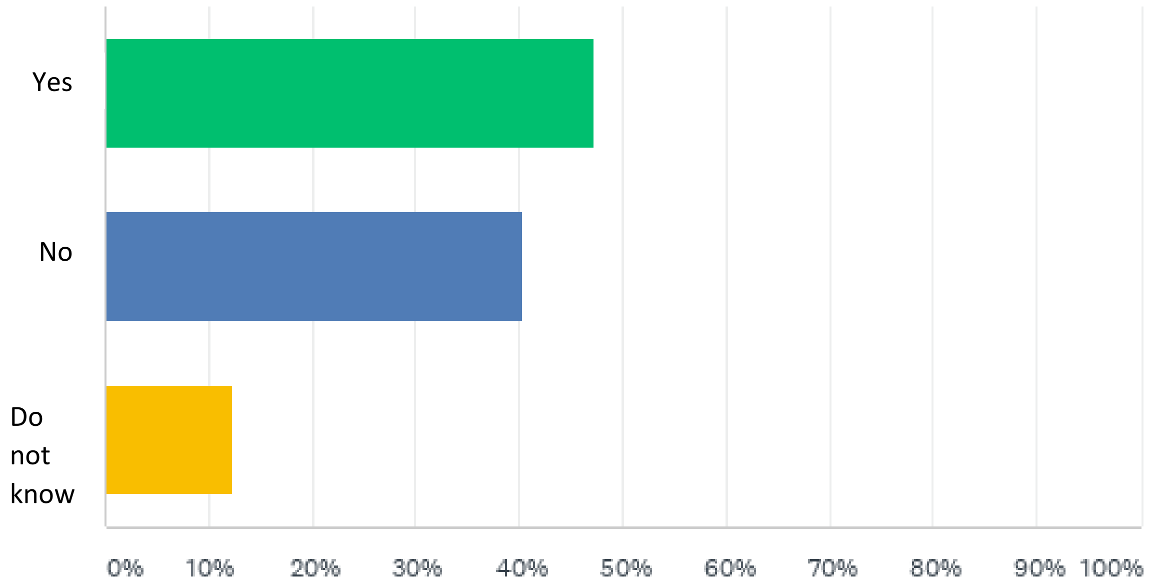
Options	%	Responses
Obviously curable	**12.5%**	**3**
Obvious and easily curable	**29.2%**	**7**
Other patient categories	**58.3%**	**14**
Total		**24**

This question should only have been completed by the 21 respondents who responded to the previous question that not all patients are assessed at the MDT Conference.

It must be assumed that there is a number of patients who falls outside the obvious MDT cases and that a considerable proportion of these fall outside for reasons other than the immediately obvious ones; 'obvious incurable', or 'obvious and easily curable'.

We have no assumption about what 'other patient categories' includes. Perhaps it is patients in whom malignancy has not been detected during the diagnostic work-up.

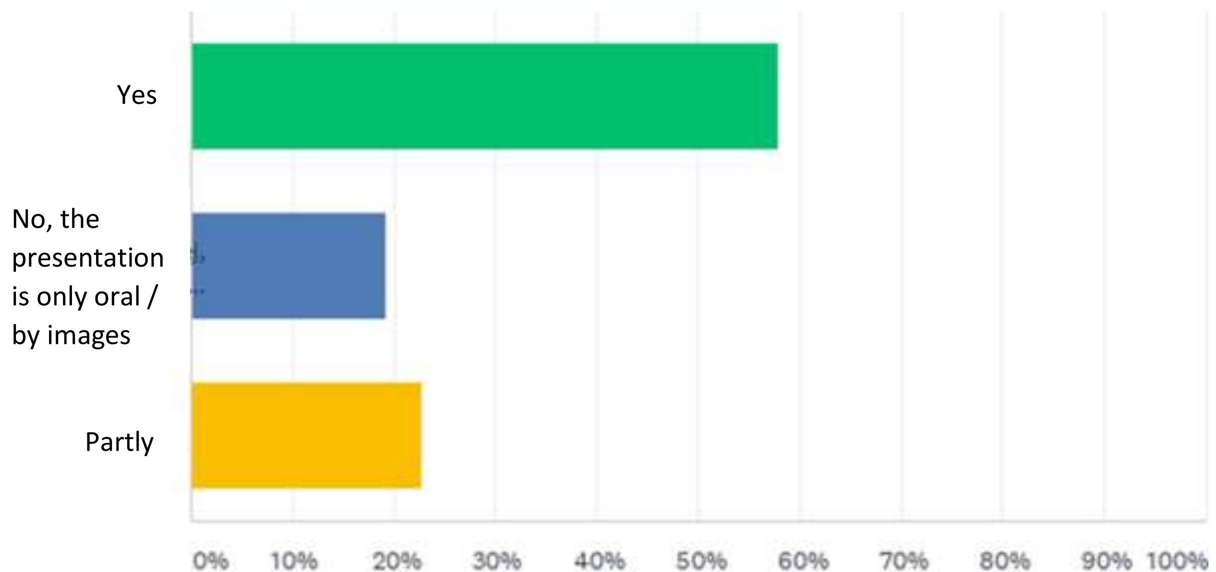
Q7: Is discussion at the MDT Conference systematically registered - either directly in the database or in the National Patient Register with a specific code?



Options	%	Responses
Yes	47.4%	27
No	40.4%	23
Do not know	12.3%	7
Total		57

The answers points to an increased focus on registration as an area which can be further developed.

Q8: Is a comprehensive written presentation (paper or digital) of the patients' findings from the diagnostic work-up available at the MDT Conference?

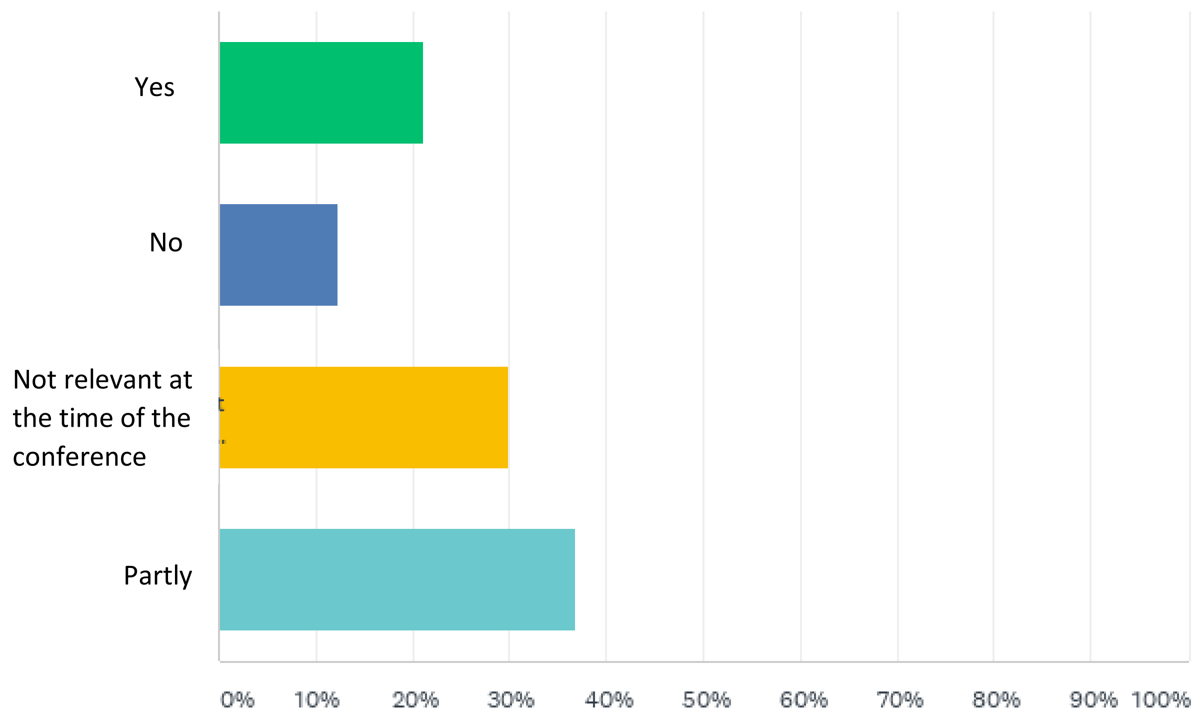


Options	%	Responses
Yes	**57.9%**	**33**
No, the presentation is only oral / pictorial	**19.3%**	**11**
Partly	**22.8%**	**13**
Total		**57**

It appears that for a sizeable proportion of patients only an oral presentation is made. Potentially this may result in not having all the relevant information at the MDT Conference. It may also indicate that there is insufficient time to prepare presentations in writing as it is indisputable that MDT Conferences have different available resources.

It is during the preparation for the conference that it should be possible to go through all the available information and have the possibility to consult others. Thorough preparation generally helps to ensure the best course of action.

Q9: Are patient preferences systematically involved in the discussion and decision-making at the MDT Conference?

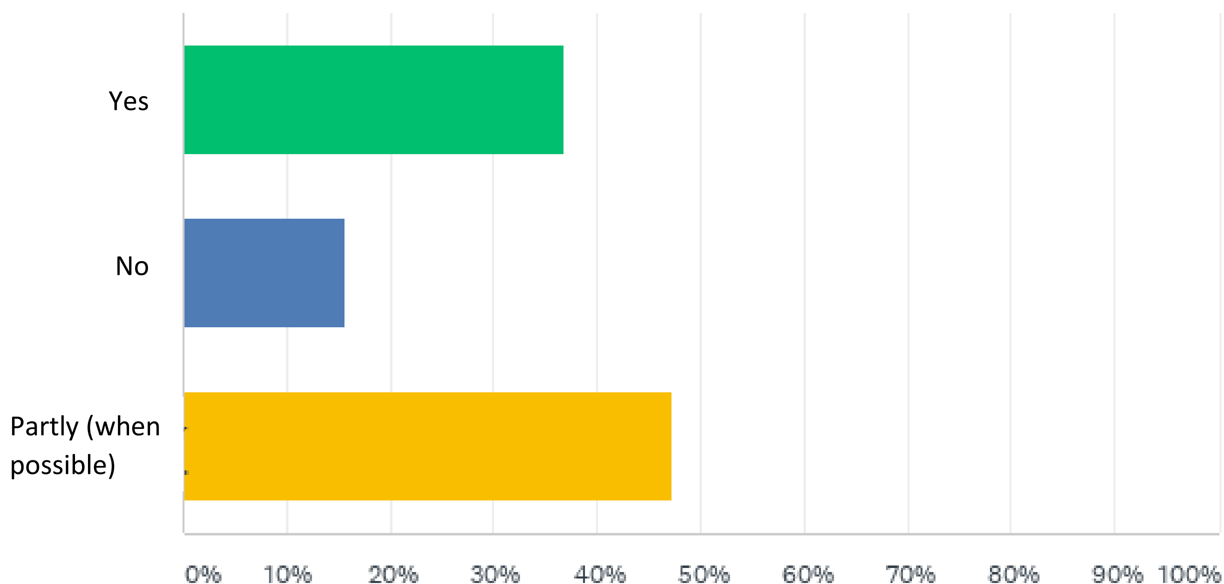


Options	%	Responses
Yes	21.1%	12
No	12.3%	7
Not relevant at the time of the MDT conference	29.8%	17
Partly	36.8%	21
Total		57

Patient involvement has been identified as essential by RKKP and DMCG. According to more than 47% of respondents/MDT Conferences, patient preferences are fully or partially included in the discussions at the MDT Conference. But for nearly 30% it is judged not to be relevant at the time of the MDT Conference.

Often the patients' preferences will not be discussed until the possible treatment options are known. It is only when the final TNM staging of the patient and the realistic options for treatment are known that preferences among treatment options are discussed. Thus, it is often only after the MDT Conference when the actual therapeutic possibilities are known that patients are involved in the decision about choise of treatment.

Q10: Do junior doctors systematically participate in the MDT Conference as a part of their education?



Options	%	Responses
Yes	**36.8%**	**21**
No	**15.8%**	**9**
Partly (when possible)	**47.4%**	**27**
Total		**57**

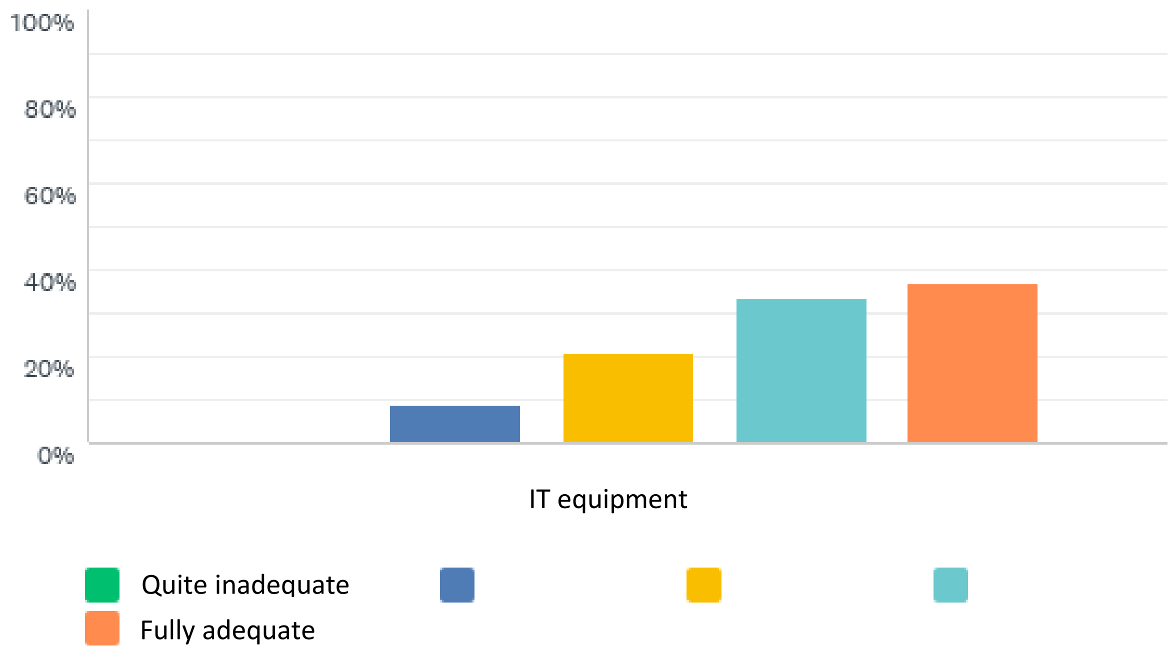
In the previously issued guideline for the organization of MDT Conferences, the MDT Committee has identified the conference as an important learning potential for junior doctors. According to the responses, conference participation is far from being prioritized in all departments. In nine out of 57 cases (16%), their participation was not planned at all, and for 47% of MDT Conferences it was only when possible – meaning that other functions had higher priority. Thus, there is an unused potential for learning here.

It appears to be difficult to take junior doctors out of the ordinary clinical work, depending on the specialty. In oncology it is generally difficult.

If you do not ensure that junior doctors participate in MDT Conferences, there is a risk that doctors who have never been to a conference before may suddenly be responsible for the conference.

Junior doctors cannot be responsible for the conference. More senior doctors should be prepared to take over the responsibility. In some specialties, systematic training for this does not seem to be ensured.

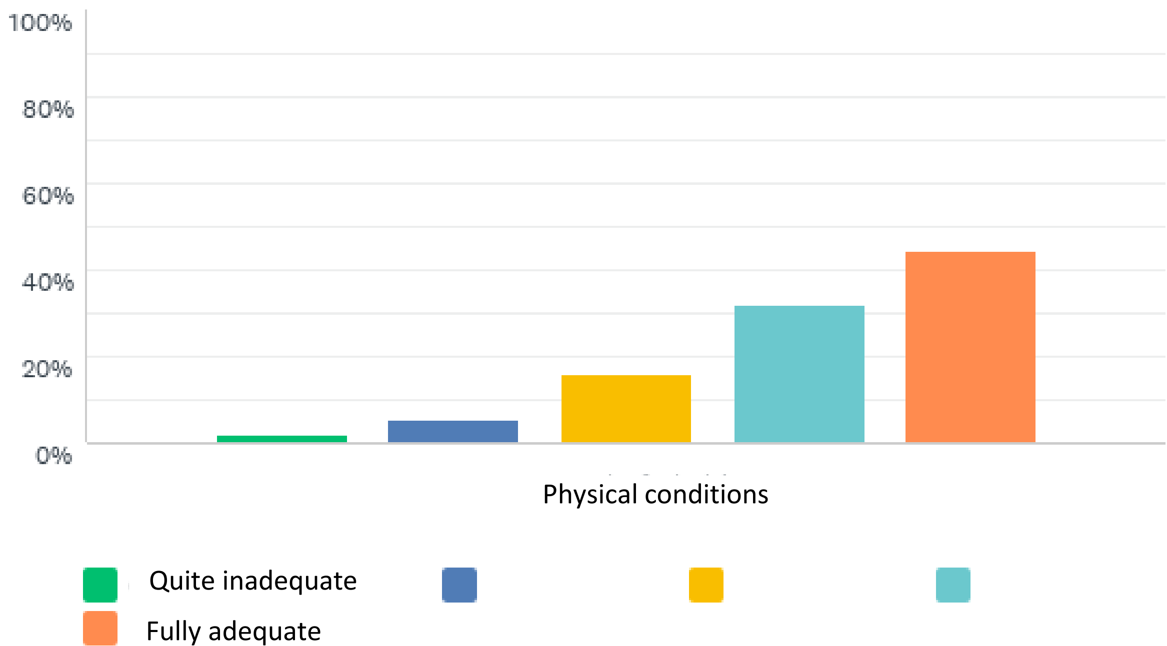
Q11: Is IT equipment for organizing the MDT Conference sufficient?
Indicate on scale from 1-5, with 1 as quite inadequate and 5 as fully adequate



IT Equipment	Quite inadequate				Fully adequate	**Total**	**Weighted average**
Number	0	5	12	19	21	**57**	**3.98**
Percentage	0%	8.8%	21.1%	33.3%	38.8%		

Compared to previous surveys, this survey shows a remarkably good result. Over the last few years, investments have been made in equipment, such as servers and other electronic equipment.

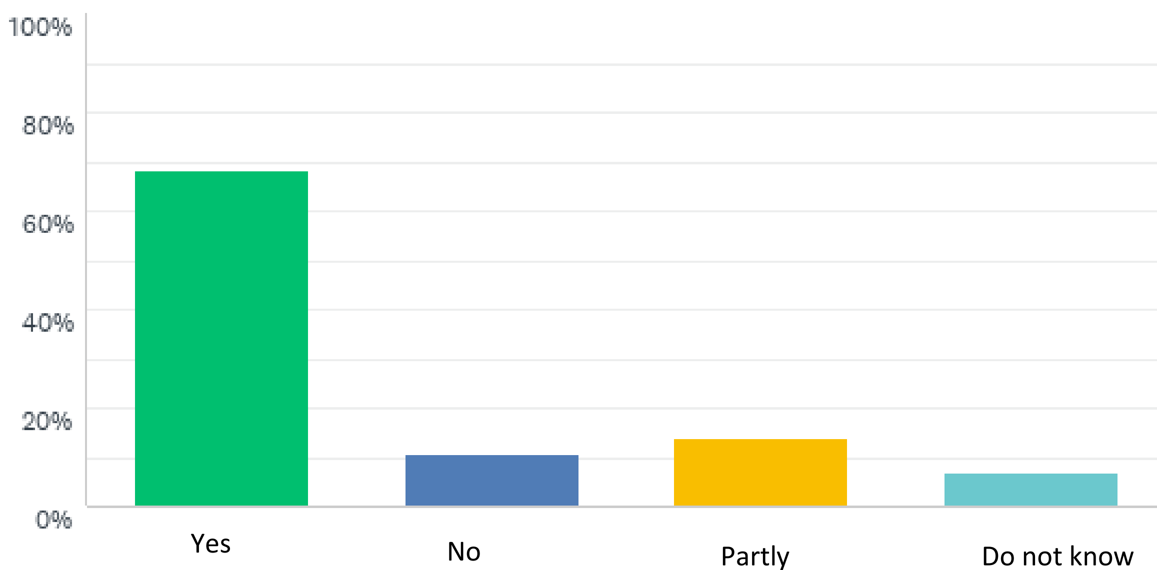
Q12: Are the physical conditions for conducting the MDT Conference adequate? Specify on a scale from 1-5, with 1 as quite inadequate and 5 as fully adequate.



Physical conditions	Quite inadequate				Fully adequate	**Total**	**Weighted average**
Number	1	3	9	18	25	**56**	**4.13**
Percentage	1.8%	5.4%	16.1%	32.1%	44.6%		

The same rather positive result as for Q11 applies here.

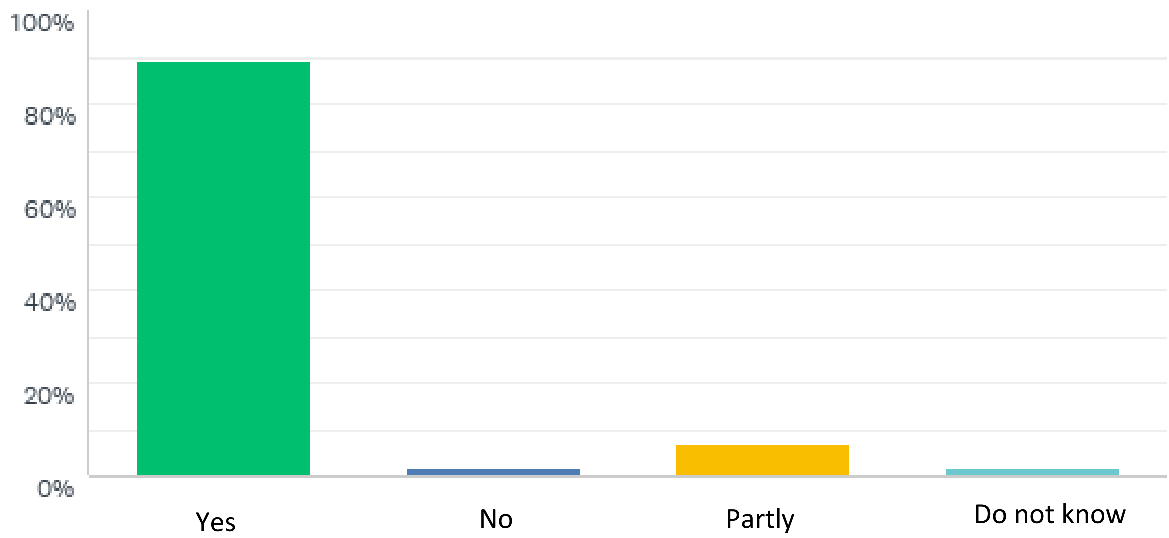
Q13: Is there a unique ownership of the conference concerning responsibility for IT?



Options	%	Responses
Yes	68.4%	39
No, the presentation is only oral / pictorial	10.5%	6
Partly	14.0%	8
Do not know	7.0%	4
Total		57

Here responses were also very positive. However, problems regarding responsibility may still arise when the MDT Conferences are conducted as video conferences across hospitals.

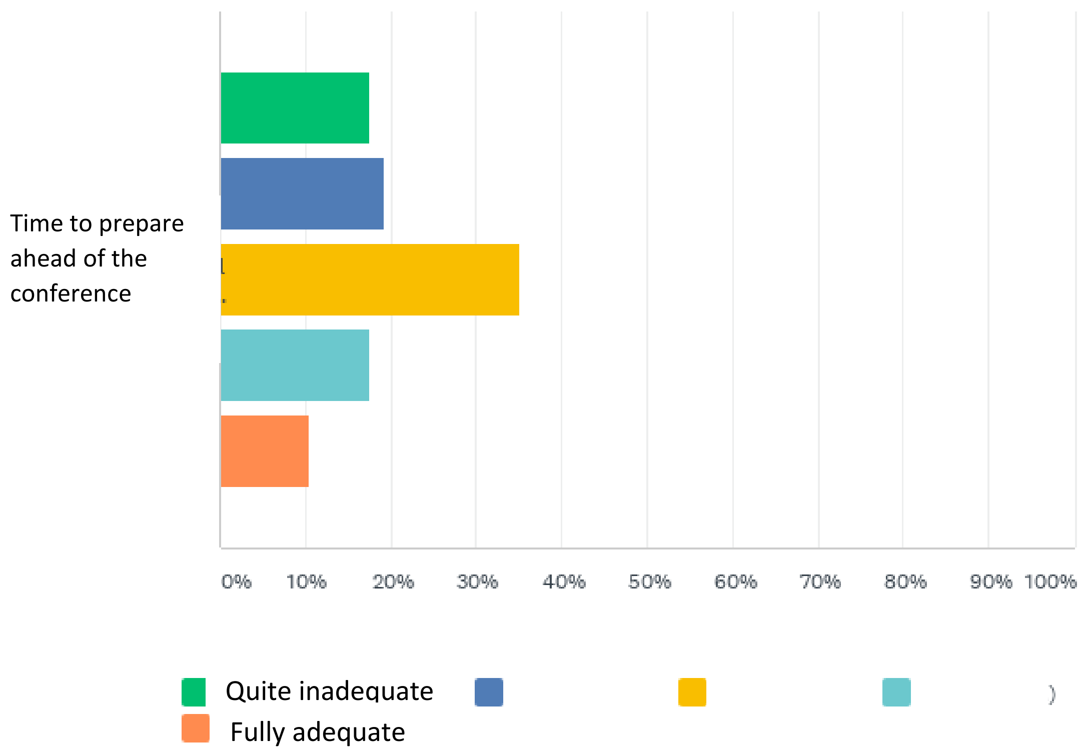
Q14: Is there a unique ownership of the conference concerning responsibility for physical conditions (conference room etc.)?



Options	%	Responses
Yes	89.5%	51
No	1.8%	1
Partly	7.0%	4
Do not know	1.8%	1
Total		57

Again, a very positive result.

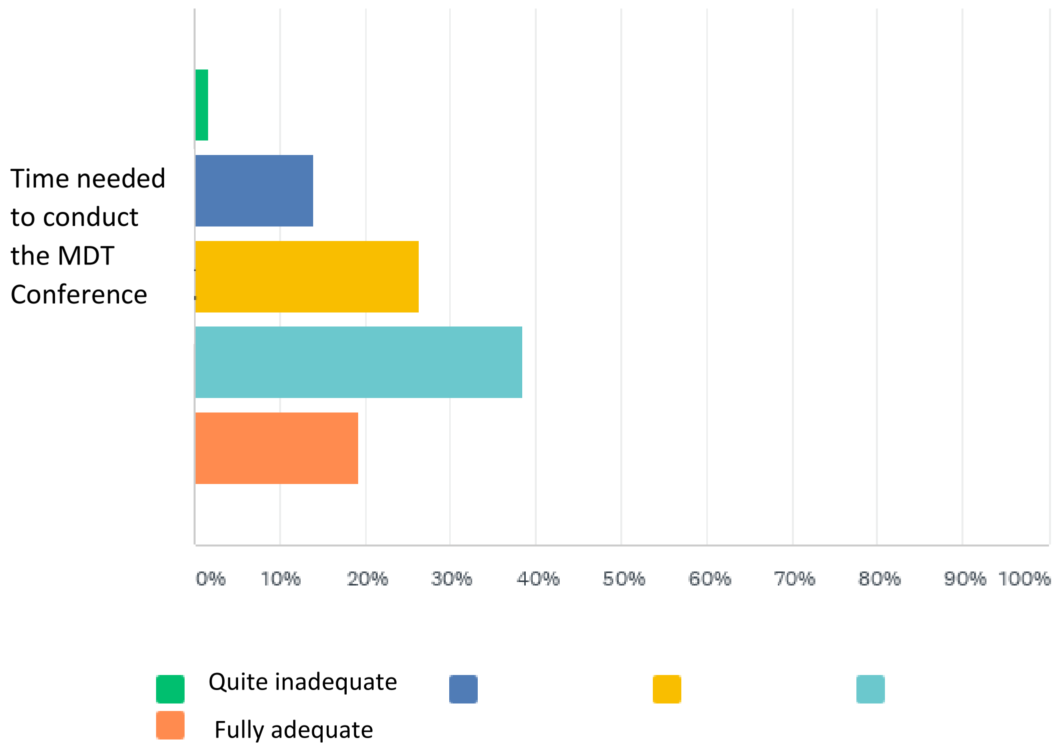
Q15: Do the participants in the MDT Conference have the time needed to prepare ahead of the conference? Specify on a scale from 1-5, with 1 as quite inadequate and 5 as fully adequate.



Time to prepare the MDT Conference	Quite inadequate				Fully adequate	**Total**	**Weighted average**
Number	10	11	20	10	6	**57**	**2.84**
Percentage	17.5%	19.3%	35.1%	17.5%	10.5%		

Preparation time seems to be an area in need of optimisation. The worse the presentation, the more time is needed at the MDT Conference itself. The need for time to prepare the conference is specialty specific. For example, the diagnostic imaging should preferably have been reviewed prior to the conference.

Q16: Is there enough time to conduct the MDT Conference?
Specify on a scale from 1-5, with 1 as quite inadequate and 5 as fully adequate



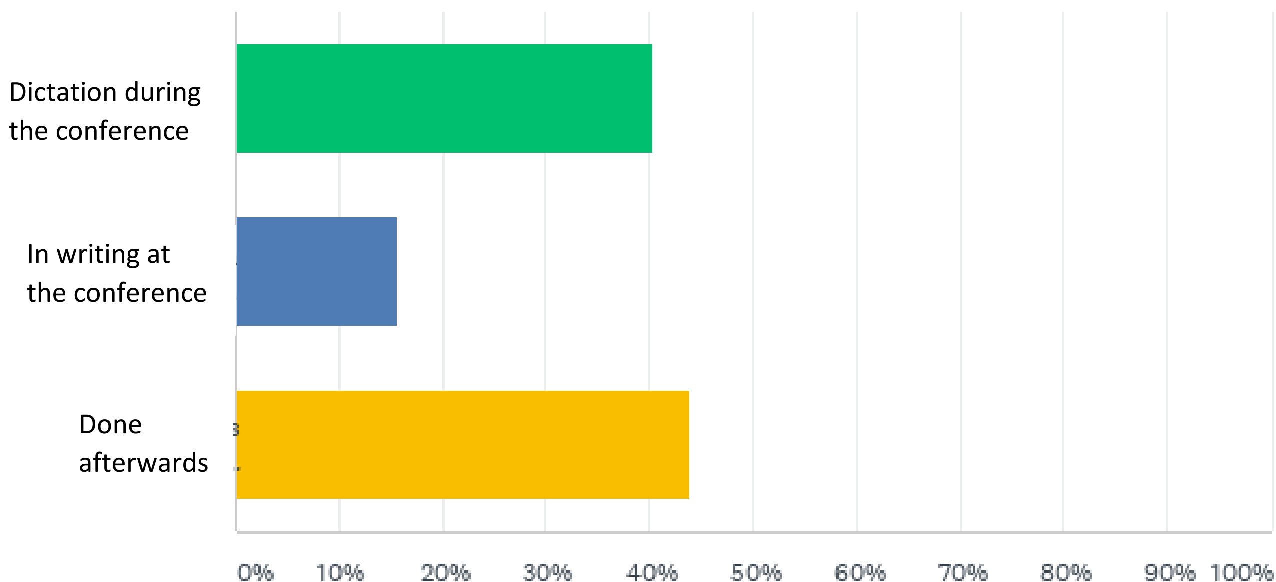
Time to hold the MDT Conference	Quite inadequate				Fully adequate	**Total**	**Weighted average**
Number	1	8	15	22	11	**57**	**3.60**
Percentage	1.8%	14.0%	26.3%	38.6%	19.3%		

There seems to be a quite high satisfaction regarding the time devoted to the conference, which is positive.

There is not necessarily a limit to the number of patients being discussed at the conference; no upper limit may result in some times very long conferences. This is an issue that should be followed up.

When the necessary time to conduct the conference is discussed, it should also be noted that there are conferences where there is a limit on the time or a limit to the number of patients to be discussed.

Q17: How do you record decisions during the MDT Conference?

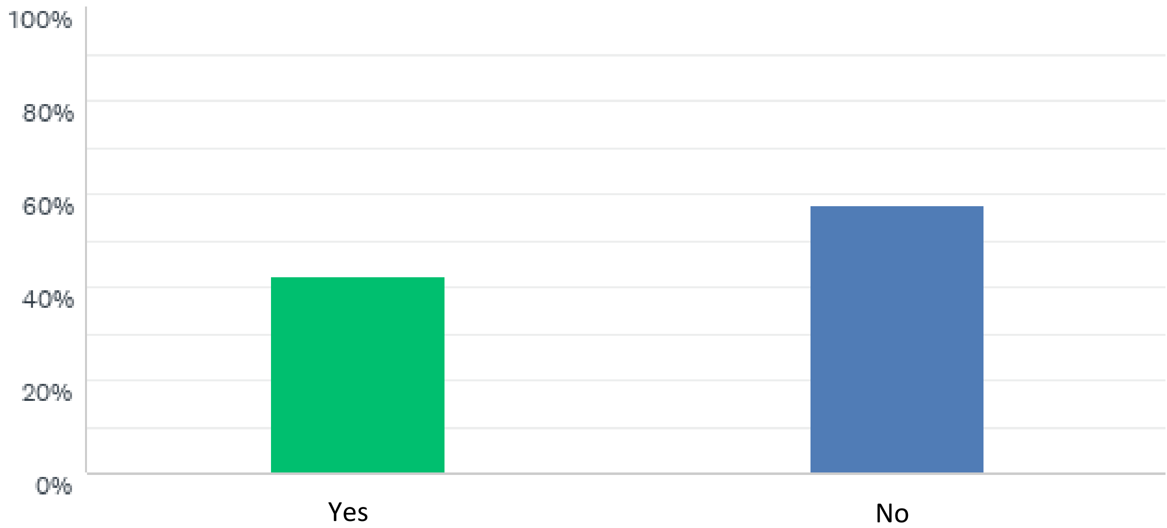


Options	%	Responses
Dictation during the conference	**40.4%**	**23**
In writing at the conference	**15.8%**	**9**
It is done afterwards	**43.9%**	**25**
Total		**57**

The responses indicate that almost half of MDT Conferences do not record decisions during the conference.

It is a recommendation in the MDT Committee's guideline to record the decisions from the conference real-time and this may be a future focus area. It should be a priority that all participants at the conference hear the conclusion of the discussion and agree to the wording of the decision. Dictating the decision real-time at the MDT Conference will support correctness – especially if overheard by the other participants at the conference for possible corrections.

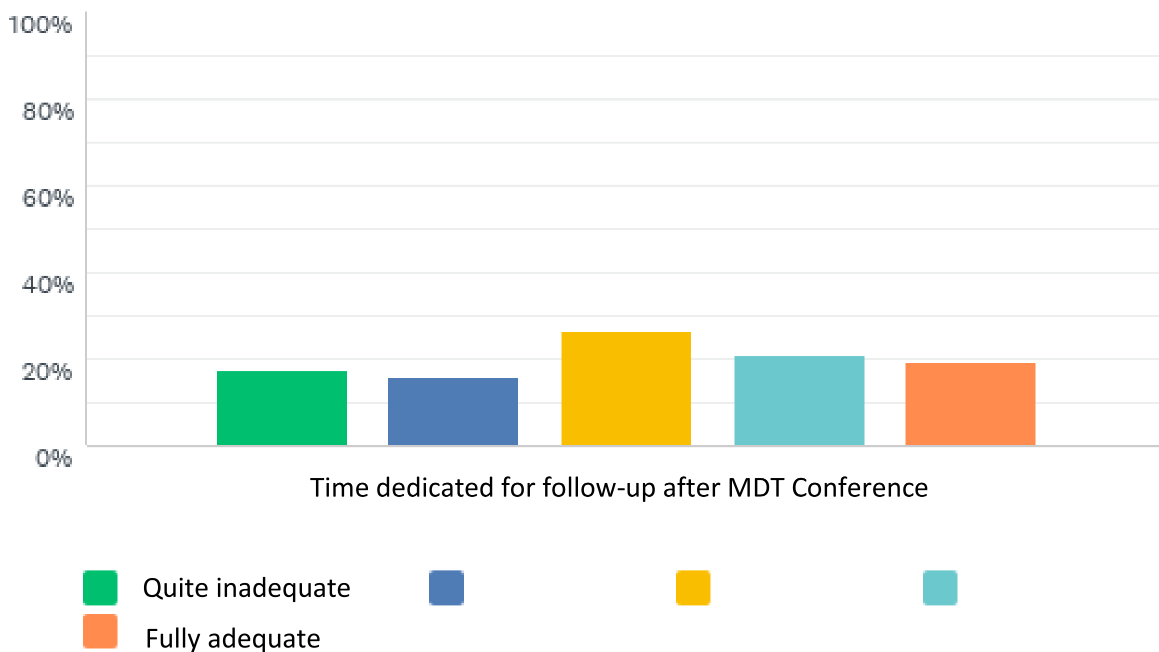
Q18: Is it systematically ensured/verified that the decision noted is a correct representation of the MDT Conference decision?



Options	%	Responses
Yes	**42.1%**	**24**
No	**57.9%**	**33**
Total		**57**

The result underlines the responses to the previous question.

Q19: Is follow-up on decisions at the MDT Conference, such as ordering any additional investigations or informing the patient about conclusions from the MDT Conference, considered to be included in the normal working hours? Specify on a scale from 1-5, with 1 as quite inadequate and 5 as fully adequate

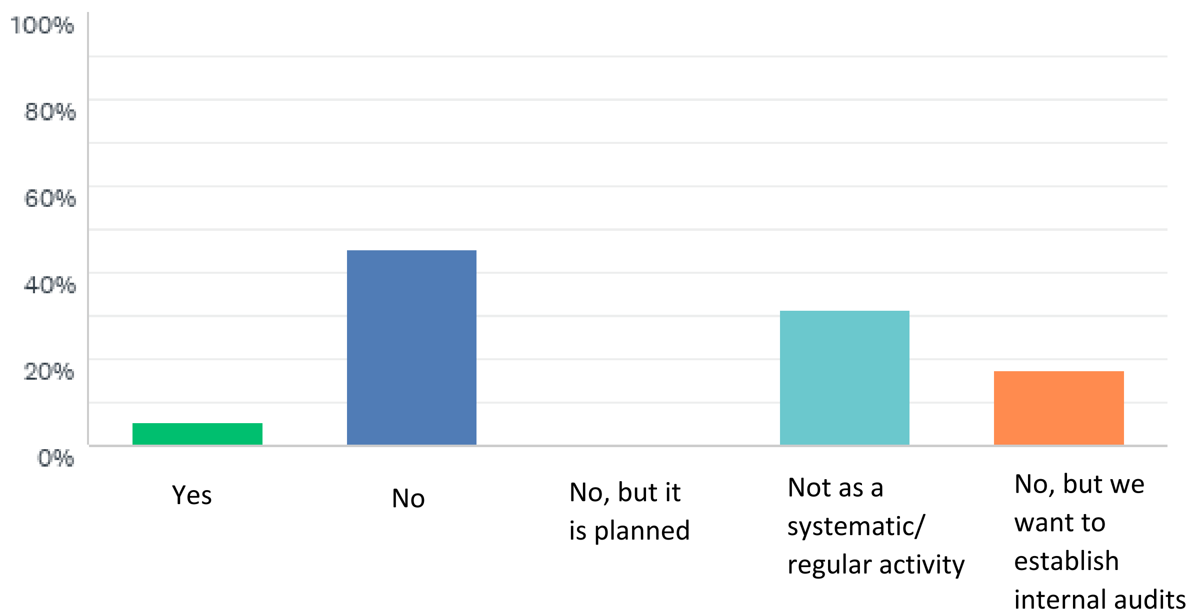


Time for follow-up after MDT Conference	Quite inadequate				Fully adequate	Total	Weighted average
Number	10	9	15	12	11	**57**	**3.09**
Percentage	17.5%	15.8%	26.3%	21.1%	19.3%		

These responses show that it is important that communicating the conclusions from the MDT conference to the patient should be included in and prioritized during working hours.

However, delays in responses to the patient may occur if it is a specific doctor who has seen the patient in advance, e.g. the surgeon, who must provide answers.

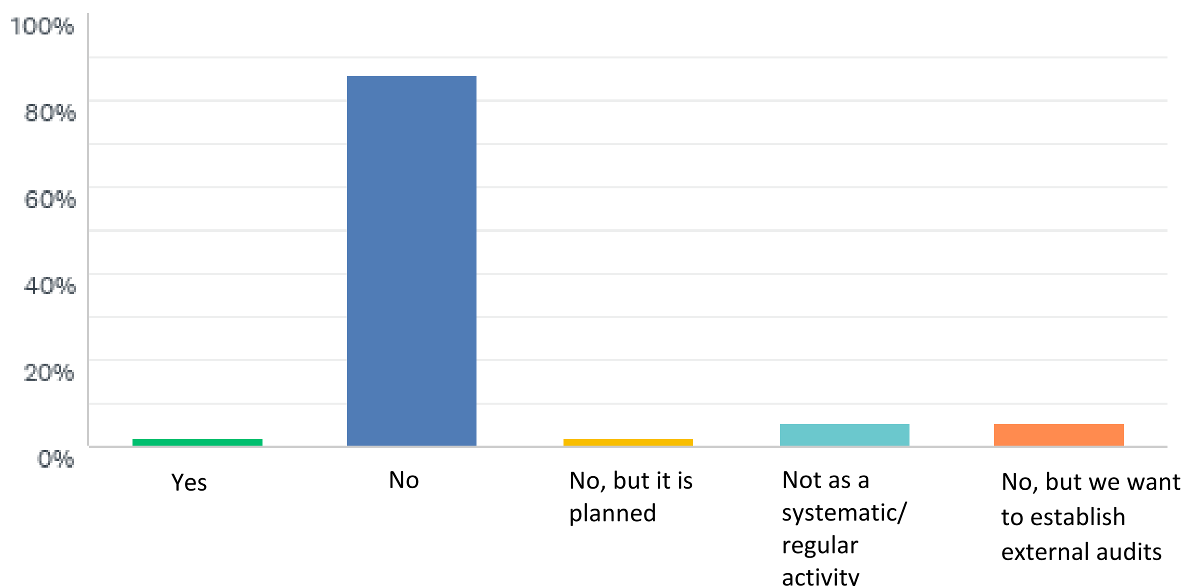
Q20: Is internal audit (in own MDT Conference) conducted to ensure that MDT decisions correspond to best practice/are in accordance with updated guidelines?



Options	%	Responses
Yes	5.3%	3
No	45.6%	26
No, but it is planned	0.0%	0
Not as a systematic/regular activity	31.6%	18
No, but we want to establish internal audits	17.5%	10
Total		57

Some make efforts to evaluate on practice. But this is an area for improvement to ensure that patients are offered the same treatment across different hospitals. We need to know whether we assess and treat patients the same way in all hospitals.

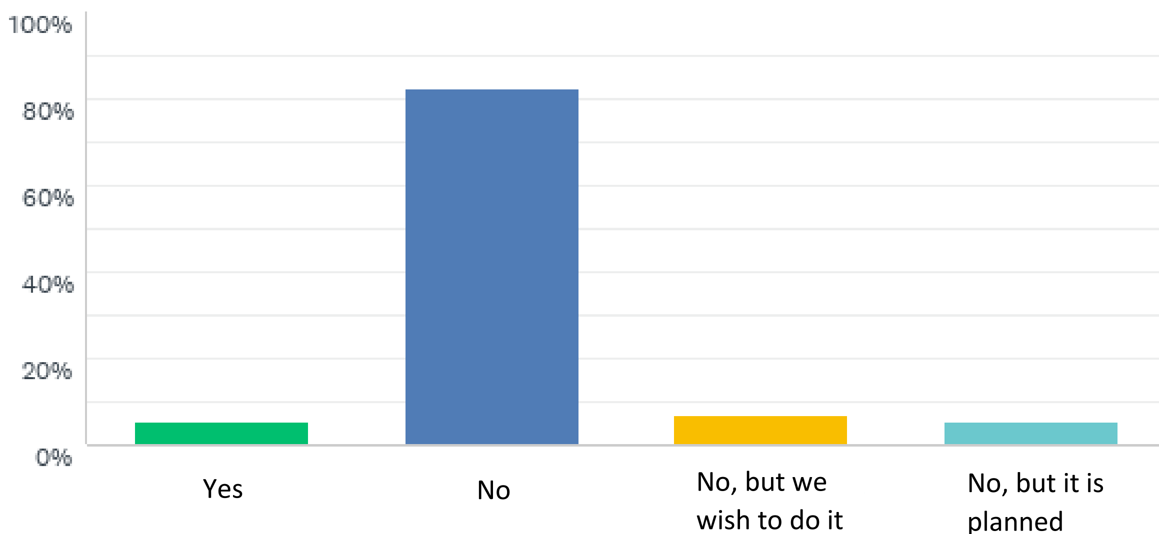
Q21: Are external audits conducted to ensure that MDT decisions correspond to best practice / are in accordance with updated guidelines e.g., by allowing another MDT within same DMCG cancer package to reassess a sample of cases without knowledge of assessment and decision regarding diagnosis, TNM categories, UICC stages and treatment offered at previous MDT conferences?



Options	%	Responses
Yes	1.8%	1
No	86.0%	49
No, but it is planned	1.8%	1
Not as a systematic/regular activity	5.3%	3
No, but we want to establish external audits	5.3%	3
Total		57

The audits on treatment decisions are obviously a major focus area, as a large proportion responded that it is not current practice to do so. We can, among other things, examine whether there are different underlying demographic conditions such as different burdens of comorbidity, just as we need to ensure that we assess patients in the same way.

Q22: Do you arrange site visits within the DMCG at other MDT conferences to exchange experiences?



Options	%	Responses
Yes	5.3%	3
No	82.5%	47
No, but we wish to do it	7.0%	4
No, but it is planned	5.3%	3
Total		57

The responses demonstrate an unused potential to get inspiration to improve own practice – at least for the 47 who responded negatively.

The MDT Committee has a budget which could be used for site visits with the MDT Committee acting as a site visit team. Such visits could preferably be organized across the country.

Summary of results from the MDT Conference survey on MDT conferences

The following trends were revealed:

- Responsibility for the vast majority of conferences lies with either the surgeons or the haematologists
- Regular participants at about 80% of all conferences are oncologists, pathologists, and radiologists
- About 63% of all patients in the DMCG cancer packages are discussed at the MDT Conference
- Among the remaining 37% of patients not discussed at the MDT Conference, 12.5% are considered obviously incurable, while 29% are considered clearly curable. Perhaps surprisingly, 58% (14 out of 24) fall into other non-specific categories
- Almost half of the MDT conferences systematically register whether a patient has been discussed at an MDT Conference, either directly in the database or in the National Patient Register
- Almost 58% of conferences have a comprehensive written (paper or digital) presentation of the patient's findings at the MDT Conference
- Almost 58% of conferences include all or part of the patient's preferences in the discussion and decision-making at the MDT Conference
- Twenty-one out of 47 conferences plan for young doctors to participate at the MDT Conference, while almost half plan to ensure this whenever possible
- Electronic equipment and physical conditions are overall satisfactory
- More than two thirds have clear ownership of the conference equipment, and almost 90% of conferences experience unambiguous ownership of physical location of the conference
- Preparation time seems to be an area that could be optimized, with just over 10% responding that they (including all conference participants) have fully sufficient time to prepare
- Time to conduct the conference is mostly seen as being sufficient
- Almost 44% of conferences do not record conference decisions at the conference
- A little less than 58% do not systematically ensure that the note regarding the decision is a correct representation of the MDT decision
- There is a wide variation in whether participants find that follow-up of decisions at the MDT Conference, such as ordering any additional investigations or giving answers to patients, is included into the planned working hours
- Only three out of 57 conferences conduct internal (at their own MDT Conference) audit that the decisions at the MDT Conference correspond to best practice/are in accordance with updated guidelines; for external audits, this applies to only one out of 57
- Site visits within the DMCG at other MDT conferences are held for three out of 57 conferences to exchange experiences.

- It should be noted that the resources used in connection with the MDT Conference are extensive for some specialties as the participants must participate in many conferences.