

VIEWS & REVIEWS



Patient commentary: Consider the person alongside the pathology

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My experience of being discussed at multidisciplinary team (MDT) meetings backs Eigenmann's view that someone who can present the patient's perspective should be there.¹ It also suggests that patients should be alerted to these meetings and might value the option to represent themselves.

As a three operation, 11 year survivor of metastatic adrenal cancer,² I knew that it was likely to come back again one day. I dreaded annual scans and happily agreed to forgo them two years ago. This year, during reappraisal of my hyperparathyroidism, recurrence was detected.

The senior registrar broke the bad news gently by phone and mentioned that my case was due to be discussed at an MDT meeting. I asked whether I might be allowed to attend and be sent a copy of the scan results in advance. The consultant kindly agreed.

I sat at the back of the room, looking at my scans on the screens, listening to the thoughtful discussion between radiologists, oncologists, and endocrinologists, and taking in their views of the findings and possible management options. Nothing that they said came as a surprise. Few patients live with cancer this long without doing their own research, and I found it very helpful to understand the rationale for their conclusions.

I valued being there

Their professionalism impressed and reassured me. So did their courtesy towards me—conveyed largely by their demeanour, for I was primarily there as a spectator, not as a participant.

I'm not sure what they felt about having me there, but it gave them insight into how well I am, and I was able to respond to questions and supply missing factual information about previous treatments in different hospitals. No one hospital holds a complete account of my history, and I've become inured to filling doctors in. I chase letters and test results like a Rottweiler, and my home file (unlike my full GP records, which take time and money to access) is always to hand.

At the end of the MDT meeting the consultant followed me out of the room and asked whether I was happy with the decision to get an opinion from the surgeon who did my last major operation (at another hospital). I hugely appreciated him doing this. Although I have long been set against a third bout of heroic abdominal surgery, the team's discussion made me realise that it would be foolish not to consider all options.

The surgeon ran through the gamut of possible surgical options when I saw him. Three months later I learnt, from a letter sent to an endocrinology colleague and copied to me, that he has concluded that my tumour is hard to resect with a clear margin and that he wants his colleague to see me and advise whether adjuvant therapy might shrink it.

Next I learnt from a copy of a report sent to my GP that my case has been discussed at a second MDT meeting. The report included a potted history, recent test results, and an item on "performance status," which read "not clear." (Well, if only they had asked.) The decision was "Mitotane and chemotherapy prior to possible surgery."

This was not welcome news: I had understood that non-invasive palliative surgical options might be offered. I know that the current oncological cocktail recommended for my cancer is highly toxic and is only "effective"—a term that does not include the patient's definition of the word—in a minority of cases.

Each other's perspective

I attend outpatients to discuss the team's decision. The consultant is engaging and upbeat. His results of holding and reducing the size of tumours of my sort are better than the unpromising ones I've read in the literature, he says. But we spend most of the consultation catching up with each other's perspective. He becomes aware of my scepticism about the trade-offs of aggressive treatment, admits that it's gruelling, and warns that I need to have a positive attitude to have any chance of staying the course.

By the end of the consultation he raises the possibility of a middle way. I then ask if he agrees that the parathyroid surgery I am undergoing the next day (which he did not know about) stands a good chance of making me feel better; he smiles and says yes—and it has. I am encouraged and suddenly glimpse the possibility that, at a future appointment, we may jointly agree management of my "dominant" problem in a way that, as Mulley underlines,³ takes account of the patient's (my) preferences.

But, as I leave, I can't quite shake off the impression of being processed by an overloaded, technologically driven system in which patients are more pawns in the game than partners in care.

Competing interests: I have read and understood the BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Eigenmann F. Multidisciplinary team meetings encourage overtreatment. *BMJ* 2015;351:h4630.

2 Richards T. Journey of a patient editor. *BMJ* 2013;347:f6913.
3 Mulley A, Trimble C, Elwyn G. Patients' preferences matter: stop the silent misdiagnosis. King's Fund 2012. www.kingsfund.org.uk/sites/files/kt/field/publication_file/patients-preferences-matter-may-2012.pdf.

Cite this as: *BMJ* 2015;351:h4878

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