The Tumor Board—
How It Works in a Community Hospital

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Many physicians who were introduced to hospital tumor boards during their training days and who have had little additional experience with them since entry into practice, have negative memories of their composition and function. There is little in the medical literature dealing specifically with tumor boards, but two recent reports have indicated that in some settings they seem to fall far short of their traditional goals: education combined with expert interdisciplinary consultation.1,2

Among contacts within the Association of Community Cancer Centers, we have informally noted much criticism of the typical tumor board in an academic institution or large community hospital. Our own experience with tumor boards in medium-sized community hospitals, however, indicates that they may be the keystone of a successful cancer program, fulfilling educational and consultative functions, but also contributing to improved patient care in other important ways. Many of our associates in small and medium-sized community hospitals have reached a similar conclusion regarding the importance of the tumor board.

The Traditional Tumor Board
In large hospitals or institutions, the tumor board is ostensibly a teaching conference, focusing on specific cancer cases that represent difficult management problems or that involve unusual and, therefore, interesting manifestations of cancer. In some institutions, the board has been expected to referee conflicting opinions about proper management and, occasionally, management has been decided by vote. Tumor board reports have been couched in dictatorial language and entered directly in the patient’s record.

Because of the large volume of cancer patients treated in major institutions, only a handful may be considered at tumor board meetings. Thus, “routine” cases are not usually included, and members of the board may never be able to get a comprehensive view of the spectrum of cancer practices in their institution. Since only difficult or unusual cases seem qualified for the tumor board’s attention, the average physician might well regard such conferences as containing little of practical value.

In addition, attempts to settle disputes

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about appropriate management have sometimes set the stage for departmental boycotts of the board meetings, arbitrariness and other unpleasantancies that hurt attendance and detract from education. For such reasons, it is not surprising that a survey of Veteran's Administration hospitals revealed that 26 percent no longer had tumor boards; of those hospitals that have continued the practice, only 57 percent had meetings at intervals less than a month apart, 34 percent indicated they were not satisfied with their boards and 60 percent felt the educational experience was questionable.1

The Tumor Board in a Small Hospital
In a hospital with less than 400 beds and an annual registration of less than 600 new cancer patients, it is possible for a tumor board, meeting weekly, to review nearly every new case and a significant number of follow-up cases. This is the key to such a board's vital function in a community cancer program. In several such hospitals, weekly attendance averages 20-30 percent of the active physician staff, and the board meetings are regarded as one of the most productive educational opportunities available. The value of such a tumor board is derived from some basic philosophical and organizational premises that differ from the traditional board in a large hospital.

Philosophy of Board Function
The traditional board is comprised of acknowledged "experts" who represent various cancer-oriented specialties. Rarely, members of allied professions, such as nurses, social workers, dentists and the clergy, may be included on the official roster. Experts may sometimes pontificate, and when they do, the way is paved for disagreement, jealousy and discord.

In a smaller community hospital, a physician dare not publicly regard himself as an expert, nor will his colleagues usually accord him such status. Therefore, a tumor board comprised of local physicians cannot be regarded as a panel of experts, and the results of its deliberations cannot be offered as the authoritative last word. Even if specialists from other institutions are invited to sit on the board, the independent community physician will usually elect to regard his statements as consultative rather than dogmatic. Consequently, the community tumor board becomes a forum for the exchange of ideas about patient management rather than a panel of experts. Its reports review important features of the case with alternative methods of management, so that the patient's physician may make an informed selection.

Even the most careful and well-informed physician may occasionally make errors in judgment, overlook significant aspects of a case, forget an important detail or be unaware of a new development. If a case is analyzed by several physicians, each from his own point of view and each with learning experiences unique to his specialty, the chances for omission or error are reduced and the opportunities for the interception of new knowledge (from medical meetings, journals or exchanges with recognized experts) are increased.

Thus, the smaller community hospital tumor board plays a primarily educational role, not a dictatorial or punitive one, and leaves final treatment decisions to the patient's own physician. He will often find the board's deliberations have refreshed his appreciation of the basics of cancer management, and perhaps added new elements of practical information. The board's organization and philosophy does not permit it to referee disputes; a wise chairman will not allow the board to damage the attending physician's ego or to become a vehicle of disciplinary action.

Organization of the Tumor Board
Depending on the size of the hospital,
the board may be comprised entirely of local staff members or it may invite outside specialists to sit in as advisors. Some remote hospitals have arranged for telephone conferences to universities or other medical centers.

Ideally, the board will be created by the Cancer Committee, which will use it as a means of discharging the bylaw-designated responsibility of reviewing every cancer case. Precedent for case review is established in every hospital approved by the Joint Commission for the Accreditation of Hospitals. The Tissue Committee has access to review of all surgically removed specimens, the Utilization Review Committee is assigned responsibility for investigating length of stay, and the Cancer Committee has the right to review all cancer cases. In this way, the tumor board and its parent Cancer Committee can achieve the necessary overview of the quality of cancer care and thus discover specific areas where education is needed. Formal audit procedures may help pin down specific problems from which educational programs may be derived. It should be remembered, however, that the informal process of active case discussion is more likely to bring about the implementation of new knowledge than is the usual formal educational effort.3

A physician who knows that his cases will always be reviewed semi-publicly at a tumor board meeting feels a certain compulsion to attend, and is thereby primed for a learning experience. He is not asked to present the case himself; the tumor board secretary abstracts it beforehand. The abstract is then rapidly reviewed by the Chairman, who may ask the physician for his comments. After contributions by the pathologist, radiologist, social worker and others involved in the patient’s care, questions and comments are solicited from any person in attendance. The report, which is dictated later, reviews important features and suggests possible management alternatives. It may simply comprise a recommendation that a specialist be consulted or that a research opinion be sought from an academic center. The report is delivered to the physician, not placed in the patient’s chart.

The Board Chairman should be chosen partly for his knowledge of cancer, and mostly for his tact and ability to promote cooperation. When it is necessary to ‘‘gag’’ an over-talkative participant, charisma probably outweighs board certification. Attention to seemingly trivial details of tumor board organization and function will assure maximum effectiveness.4-6

The Educational Function
The tumor board contributes to the education of physicians and allied health professionals in a number of ways:

- Review of basic cancer management principles is essential. While patients may be mismanaged because physicians are unaware of certain sophisticated new techniques, more tragic blunders occur because basic principles are either ignored or unknown. Only by reviewing every cancer case can these terrible errors be prevented. It is a truism, but worth considering, that a physician will not seek education about a specific point if he does not recognize he is ignorant of it. The tumor board review process brings blind areas very clearly to the physician’s consciousness. This can be done in a non-punitive way, so that learning is facilitated without damaging the ego.

- Introduction of new information occurs as tumor board members and guests contribute what they have learned from medical meetings, journals and other contacts. Significant contributions of this type may be expanded into formal presentations at staff meetings, where their importance may be emphasized by pointing
out applicability to cases currently being seen in the hospital. Interest generated by tumor board discussions of new techniques may stimulate the Cancer Committee to invite guest speakers for staff seminars or conferences. The case-specificity of new knowledge facilitates its assimilation into the day-to-day practices of physicians.

Opportunities for research are discovered in the course of tumor board discussions. Such research may be applicable only to the local medical environment, and may be as simple as comparing the cost effectiveness of two alternative laboratory methods. But if patient care can be improved by such study, it is certainly worthwhile. Numerous opportunities for significant research in community hospital settings exist, but physicians are seldom "turned on" to these possibilities.

In its function as a multidisciplinary conference, the tumor board educates allied professionals. The Cancer Committee may assist nursing in-service education by filling information gaps among the nursing personnel. The effectiveness of social workers and clergy are increased by their exposure to cancer case discussion, and their observation of the interplay of fact and opinion, knowledge and judgment. At the same time, physicians are educated to the roles of the so-called "paraprofessionals," so that all hospital and community resources may be used to the patient's advantage.

Community outreach projects are suggested as areas of deficiency in lay education become apparent. For example, a high incidence of advanced cervical cancer highlights the need for cooperative efforts by local American Cancer Society representatives, newspapers and other community resources, perhaps culminating in a meaningful cancer detection program. The tumor board can publicize its existence in local media, and will find that the public responds positively to the concept of physicians meeting together, without pay, for the sake of promoting quality cancer care.

Summary

In the small or medium-sized community hospital, the tumor board differs in philosophy, organization and function from its traditional counterpart in a large institution. It provides a means for discussing all cancer cases, so that a physician can make educated judgments about management. It facilitates the review of basic principles of cancer care, the introduction of new techniques and knowledge, the intelligent referral of patients to appropriate specialists or centers, and the assessment of overall performance so that areas of weakness may be remedied by appropriate educational programs. With good leadership, it may be a vehicle for increased cooperation and trust between physicians, as well as allied health professionals. Properly run, the tumor board may be the most valuable educational tool available to the hospital staff, and the cornerstone of a successful community cancer program.

References

1. Smith, B.H.: Is the tumor board doomed? JAMA 233:1048, 1975 and 236:1235-1236, 1976.
2. Berman, H.L.: The tumor board: is it worth saving? Milit. Med. 140:529-531, 1975.
3. Nelson, A.R.: Orphan data and the unclosed loop: a dilemma in PSRO and medical audit. N. Engl. J. Med. 295:617-619, 1976.
4. Burk, L.B., Jr.: Developing a cancer clinical program in a community hospital. Bull. Amer. Coll. Surg. 53:3-8, 1968.
5. Jonas, K.C.: Establishment and function of a clinical cancer program in a private hospital. Med. Ann. D.C. 40:172-174, 1971.
6. Association of Community Cancer Centers Delegate Manual, Sections 1, IX, 1976.