A review on the impact of lung cancer multidisciplinary care on patient outcomes

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Abstract: International guidelines recommend a multidisciplinary approach to the management of lung cancer due to the complexity of both patients and their disease and the multiple treatment options available. This can be provided through patient discussion at multidisciplinary meetings where relevant medical and allied health staff formulate a consensus management plan taking all factors into consideration. This model can be extended further to include multidisciplinary clinics where the patient is present for assessment and discussion. However, conducting regular multidisciplinary meetings or clinics has significant time, resource and financial costs and therefore, it is important to assess the impact of multidisciplinary care. We aimed to review published evidence, from 2000 to 2019, to evaluate the impact of multidisciplinary care on lung cancer outcomes. There were 29 studies found, 11 evaluating multidisciplinary clinics, 14 studying multidisciplinary meetings and four where the model of care was not defined. There was only one randomised trial and three prospective studies, the remainder being retrospective studies. Despite limitations in trial design and confounding factors, overall, multidisciplinary care in lung cancer was associated with improvements in patient outcomes, in particular improved survival for all stages of lung cancer. Lung cancer patients managed in a multidisciplinary setting were more likely to receive active treatment and had improved utilisation of all treatment modalities: surgery, radiotherapy and chemotherapy. In addition, the treatment recommendations were more likely to be consistent with lung cancer management guidelines. These improved outcomes support the recommendations for a multidisciplinary approach to lung cancer care.

Keywords: Multidisciplinary care; lung cancer; survival; treatment utilisation; guideline adherence

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Introduction

Lung cancer management is challenging due to the underlying biological diversity of the disease and the complexity of its patient population. Many factors, including stage, histology, age, comorbidities, symptoms, patient performance status and preference impact on management. Active treatment options include surgery, radiation therapy and systemic therapy in the form of chemotherapy, targeted therapies or immunotherapy. Frequently a combination of two or three modalities may be used. In patients with advanced disease and those with significant comorbidities or poor performance status a palliative approach to treatment may be most appropriate. The multiplicity of treatment options requires close collaboration between multiple specialists in order to develop a management plan based on evidence and tailored to individual patients.
This collaboration is the cornerstone of multidisciplinary care. Multidisciplinary care refers to medical care that is provided by a number of different medical and allied health specialties, who meet regularly to prospectively share, weigh and synthesise information relating to individual patients. Following discussion, a collective decision regarding the most appropriate management options, including the need for further investigations or treatment, is made. In lung cancer multidisciplinary care is provided by radiation oncologists, medical oncologists, thoracic surgeons, respiratory physicians, radiologists, pathologists, nuclear medicine physicians, and palliative care. Other health professionals may also be involved, including nursing, social workers and pharmacists.

Multidisciplinary care as part of lung cancer management has been recommended in a number of international management guidelines in the USA (1-3), the UK (4), Australia (5), and France (6). Multidisciplinary cancer care is one of the ten goals outlined in the Quality Cancer Care Statement by the American Society of Clinical Oncology (ASCO)-the European Society for Medical Oncology (ESMO) (3), which states the “Optimal treatment of cancer should be provided by a team that includes, where appropriate, multidisciplinary medical expertise composed of medical oncologists, surgical oncologists, radiation oncologists, palliative care experts, as well as oncology nurses and social workers. Patients should also have access to counselling for their psychological, nutritional, and other needs.” The Australian National Service Improvement Framework for Cancers outlines the need to develop strategies to encourage participation by clinicians and health care providers in multidisciplinary care (7). The National Comprehensive Cancer Network (NCCN) guidelines for the management of lung cancer specifically, recommend the diagnosis and treatment of lung cancer should be based on a consensus of specialists in a multidisciplinary setting (1,2).

In addition, patient assessment in a multidisciplinary setting is a published key performance indicator (KPI) for lung cancer in some jurisdictions (8,9).

There are several models of multidisciplinary care delivery. One model is a regular multidisciplinary meeting (MDM), case conference, or tumour board where a quorum of treating specialists attend a regular meeting to present and discuss individual patients and make decisions on patient care. MDMs may be held as a face-to-face meeting or as a virtual or teleconferenced meeting if distance is prohibitive (10,11). A second model of care is a multidisciplinary clinic (MDC) where a centralised lung cancer clinic is established, and patients are able to see the appropriate specialists within this clinic. An MDM is frequently arranged either prior to or following the MDC.

Measuring the impact lung multidisciplinary care has on patient outcomes is difficult, due to the lack of randomised controlled trials and multiple confounding factors. Patients reviewed in a multidisciplinary setting are younger and tend to have early stage disease, fewer comorbidities, and better performance status (12-16). Patient age, comorbidity score, cancer stage and service volume of the hospital are factors associated with multidisciplinary care (14). It can be difficult to separate out the effects of multidisciplinary care from those related to patient or institutional factors.

A number of different studies have sought to assess the impact of multidisciplinary care in terms of outcomes for lung cancer patients. A multitude of outcomes have been assessed in these studies, including the impact of multidisciplinary care on survival; treatment utilisation; adherence to guideline treatment; the timeliness of treatment; referral to palliative care; quality of life (QOL); patient satisfaction; and enrolment in clinical trials. This review summarises the trials published, from 2000 to 2019, which examine the impact of multidisciplinary care on lung cancer outcomes (Table 1).

Impact on survival

The evidence for the impact of multidisciplinary care on lung cancer survival is varied, ranging from a statistically significant improved survival for patients who were managed via an MDM or MDC (12-15,26,28,30,35,36); to a non-significant trend towards improved survival (24); and finally no survival benefit in patients (10,17,27,37).

One study randomised patients with a possible diagnosis of lung cancer to workup at a centralised tertiary centre MDM or to conventional workup locally. There was no difference in survival between patients randomised to the two arms either overall or for patients receiving curative treatment (27). This study was limited by a small sample size and approximately one third of patients having a non-cancer diagnosis. A retrospective review of lung cancer patients at a single institution also found discussion at an MDM had no impact on survival for patients with lung cancer [odds ratio (OR) 1.0: 95% CI, 0.86–1.17] (10).

Given that over 80% of patients had locally advanced or metastatic disease in both groups, this finding is consistent with expected survival outcomes in this cohort. Another retrospective study found no difference when comparing the median survival pre- and post-establishment of an
Table 1 Summary of studies reporting the impact of multidisciplinary care in lung cancer on patient outcomes

| Reference | Patient cohort and study design | Study design | Nature of multidisciplinary care | Study limitations | Survival | Treatment utilisation | Timeliness | Guideline treatment | Other outcomes |
|-----------|---------------------------------|-------------|----------------------------------|------------------|----------|-----------------------|------------|---------------------|-----------------|
| Riedel et al. (2006) USA (17) | N=145 NSCLC patients, 1999–2005 244 MDC + MDM patients, 101 MDM-alone patients (NB—this group was from the time following cessation of the MDC. Patients were discussed at an MDM) | Retrospective pre- and post-test audit | MDC + weekly MDM attended by respiratory physicians, medical oncologists, and radiation oncologists at a single Veteran Affairs institution. MDM was attended by the specialists involved in the MDC as well as thoracic surgeons, radiologists, and pathologists. Following cessation of the MDC, the weekly MDM continued. | Retrospective trial design. Male only population | No difference in 1-year survival in the MDC and MDM-alone patients (i.e., seen subsequent to the cessation of the MDC) | NR | Similar time to diagnosis and time to treatment for patients seen in the MDC and MDM-alone | Clinical trials—increased proportion of MDC patients enrolled on clinical trials compared to MDM-alone patients |
| Conran et al. (2007) Australia (18) | N=431 Lung cancer patients, Sep. 2002–Sep. 2004 | Retrospective cohort, no comparison group | Weekly MDC + MDM at a single institution. Thoracic surgery, respiratory physician, medical oncologist, radiation oncologist, radiologist, pathologist, palliative care physician, lung cancer nurse coordinator. | Retrospective study | NR | NR | Treatment (surgery, radiotherapy or chemotherapy) started within recommended timeframe as outlined in international guidelines | NR |
| Seek et al. (2007) Australia (19) | Patient numbers not reported All lung cancer patients Timeframe not reported | Retrospective pre- and post-test cohort study | Fortnightly MDC + MDM at a single institution. Thoracic surgery, respiratory physician, medical oncologist, radiation oncologist, nurse practitioners. | Retrospective study | Patient numbers and time frame of study not reported | No comparison group to assess impact of patient satisfaction | Time from diagnosis to treatment improved following establishing the MDC | Patient satisfaction—high levels of patient satisfaction with MDC |
| Biegonich-Wiedman et al. (2010) USA (20) | N=46 Lung cancer MDC patients between 2007–2009 | Retrospective pre- and post-test study | MDC every third week attended by surgeon, respiratory physicians, medical oncologist, radiation oncologist, and a care coordinator at a regional hospital. | Retrospective trial design | Small numbers | No comparison group not clearly defined | Reduction in time to curative treatment following establishing the MDC | Patient satisfaction—high levels of patient satisfaction in both the pre- and post-MDC groups |
| Horanath et al. (2010) USA (21) | Patient numbers not reported Patients seen in lung and gynaeology MDC Timeframe not reported | Retrospective pre- and post-test cohort study | Weekly MDC + MDM at a single institution. Cardiothoracic surgery, respiratory physician, medical oncologist, radiation oncologist, palliative care physician, allied health and nurse practitioners. | Retrospective study | Patient numbers and time frame of study not reported | No comparison group to assess impact of patient satisfaction | Improved time from MDC to treatment (for surgery, chemotherapy, radiotherapy) compared to the time taken prior to establishing the MDC | Palliative care—improved rate of referral to palliative care following the setup with the MDC |
| Smith et al. (2012) UK (22) | N=497 NSCLC patients seen in the palliative care clinic, Jan 2009–Jan 2011 No comparison group | Qualitative study, abstract only | Weekly MDC attended by respiratory physicians, thoracic oncologist, palliative care physician, lung cancer nurse, and clinical trials. | Retrospective design | No comparison group | Abstract only Qualitative study | Patient satisfaction—improved service provision, reduced referral time, reduced transport costs, smooth transition between services: Clinic trials—improved access to clinical trials | Patient satisfaction—patient satisfaction and care giving preferred the multidisciplinary approach, improved efficiency, improved coordination and communication in the MDC |
| Kedia et al. (2015) USA (23) | N=46 Focus groups for patients with lung cancer their caregivers diagnosed seen within or outside of the MDC. Mar 2013–Jan 2014 22 patients, 24 caregivers | Prospective post-test qualitative study with comparison group | Weekly MDC attended by thoracic surgeon, respiratory physician, medical oncologist, radiology support, and a nurse coordinator | Small sample size | Single institution | Comparison group not clearly defined | | |
Table 1 (continued)

| Reference | Patient cohort and study design | Study design | Nature of multidisciplinary care | Study limitations | Survival | Treatment utilisation | Timeliness | Guideline treatment | Other outcomes |
|-----------|-------------------------------|-------------|---------------------------------|------------------|----------|----------------------|------------|-------------------|-----------------|
| Friedman et al. (2016) USA (24) | Stage II NSCLC patients, Mar 2010–Mar 2013 52 MDC patients, 57 non-MDC patients | Retrospective post-test design with comparison group | Weekly MDC + MDM at a single institution. Thoracic surgery, respiratory physician, medical oncologist, radiation oncologist, radiologist, palliative care physician, dieticians, and nurse coordinator | Referral to MDC based on referring clinician preference | Retrospective study | Single institution | Referral bias | Performance status not recorded | No comparison group to assess impact of patient satisfaction | MDC patients had a higher rate of mediastinal staging of enlarged lymph nodes | Improved time from diagnosis to treatment for MDC patients | ADC patients more likely to be recommended treatment as per hospital guidelines | Patient satisfaction—high levels of patient satisfaction with MDC |
| Senter et al. (2016) USA (25) | Non-metastatic NSCLC patients treated with curative CRT, 2006-2014 159 MDC patients, 169 non-MDC patients | Retrospective post-test design with comparison group, abstract only | MDC + MDM in a single tertiary academic centre | No comparison group not defined | Retrospective design | Single institution | | \_ \_ | Improved median survival in patients seen in the MDC compared to the non-MDC group | NR | NR | NR |
| Billfinger et al. (2018) USA (12) | All lung cancer cases diagnosed, 2002–2016 1,956 MDC patients, 2,315 non-MDC patients | Retrospective post-test design with comparison group | Co-located lung cancer MDC + MDM at a single institution | Thoracic surgery, respiratory physician, medical oncologist, radiation oncologist, nurse practitioner. Radiology, interventional radiology, allied health available on site | Retrospective study | Single institution | Referral bias | Registry data | Earlier registration of MDC patients compared to non-MDC patients | Review in MDC associated with increased short- and long-term overall survival for all stages | MDC patients were 2.5 times more likely to undergo surgery. Similar rates of radiotherapy. Fewer MDC patients referred for chemotherapy | NR | NR | NR |
| Voog et al. (2017) USA (16) | Stage II-III lung cancer patients treated with multimodality therapy, Jul 2007–Jan 2015 136 MDC patients, 161 Non-MDC patients | Retrospective pre- and post-test study | Weekly MDC + MDM at a single tertiary institution. Thoracic surgery, respiratory physician, medical oncologist, radiation oncologist, allied health and nurse practitioner | | Retrospective review | Time effect | | | Improved time to review following MDC establishment | NR | NR | NR |
| Prow et al. (2020) Scotland (29) | NSCLC patients over 70, registered in a radiation oncology department in a single institution 260 MDC patients in 2020, 262 pre-MDC patients from 1995 (prior to the MDM) | Retrospective pre- and post-test audit, abstract only | 3 regular MDMs in South East Scotland with 3 specified respiratory oncologists | 3 regular MDMs in South East Scotland with 3 specified respiratory oncologists | Abstract only available Time effect | Retrospective study design | | | Improved 1-year survival of NSCLC patients aged over 70 years post set-up of an MDM | Increased rates of curative radiotherapy and a reduced rate of palliative thoracic radiotherapy following the establishment of an MDM | NR | NR | NR |
| Murray et al. (2003) UK (37) | Patients with suspected lung cancer in 1 of 3 regional clinics, Oct 1998–Jan 2001 45 patients in the central MDM arm, 43 patients in the conventional arm. | Randomised controlled trial | Centralised MDM at tertiary hospital attended by thoracic surgeons, respiratory physicians, medical oncologists, clinical oncologists, palliative care physicians, and study coordinator | Small sample size High proportion of non-cancer diagnoses | No difference in survival either overall or for patients receiving radical treatment between the 2 arms | | | There was a trend towards increased curative treatment in the MDM arm (NS). MDM arm patients twice as likely to have chemotherapy (mostly palliative treatment) | There was a 4 week improvement in the time from presentation to treatment in the MDM arm, but no difference in the time from diagnosis to radical treatment | GOL—equivalent GOL | Patient satisfaction—improved patient satisfaction in the MDM arm. Concerns in the conventional arm about the timeframes to diagnosis and treatment | NR |
| Davison et al. (2004) Scotland (31) | Lung cancer patients discussed at MDM, Nov 2000–Nov 2001 Comparison group, 50 patients undergoing thoracotomy in the 5 years prior to the MDM | Retrospective pre- and post-test study | Fortnightly teleconference MDM between a national centre and metropolitan tertiary hospital. Attended by thoracic surgeons, respiratory physicians, medical oncologists, clinical oncologists, radiotherapists, and lung cancer nurse coordinator | | Retrospective design | Single institution | Comparator group not clearly defined Small patient numbers | NR | Surgery rates increased following setup MDM with improved referral pathways | Tended to reduced time from MDM discussion to surgery (NS) | © Translational Lung Cancer Research. All rights reserved. Transl Lung Cancer Res 2020;9(4):1639-1653 | http://dx.doi.org/10.21037/tlcr.2019.11.03 |
Following the setup of the lung MDM, rates of surgery and chemotherapy increased; more patients received curative surgery rates were unchanged apart from stage IIIA where there was an increased surgery rate; more patients received neoadjuvant chemotherapy and there were improved rates of complete preoperative staging. MDM patients were more likely to receive curative treatment as per NCCN Guidelines. Palliative care—MDM patients had trend to increased referral to palliative care (NS). Clinical Trials—trend to increased enrolment in clinical trials (NS) for MDM patients.

| Reference | Patient cohort and study design | Study design | Nature of multidisciplinary care | Study limitations | Survival | Treatment utilisation | Timeliness | Guideline treatment | Other outcomes |
|-----------|---------------------------------|-------------|---------------------------------|------------------|---------|-----------------------|------------|-------------------|---------------|
| Forastier et al. (2005) UK (28) | N=243 Inoperable NSCLC (stage III/IV) patients, diagnosed in 1997 (pre-MDM) and 2001 (post-MDM) | Retrospective pre- and post-test study | An MDM consisting of with two respiratory physicians, two surgeons, a medical oncologist, a clinical oncologist, a palliative care physician, a radiologist and a lung cancer nurse at a single tertiary hospital | Retrospective study | Improved median survival in the MDM patients | MDM patients had increased rates of active treatment and chemotherapy. Rates of radiotherapy with curative or palliative intent remained unchanged | NR | NR | NR |
| Stave et al. (2006) NZ (29) | N=140 Stage I or II NSCLC patients, 2004 | Retrospective post-test design, with comparison group | MDM attended by cardiothoracic surgeons, respiratory physicians, medical oncologists, radiation oncologists, and radiologists | Retrospective design | NR | Patients with stage I or II disease discussed at MDM were more likely to undergo curative treatment | NR | NR | NR |
| Bydder et al. (2006) Australia (30) | N=98 Inoperable NSCLC (stage IV) patients, 2005 | Retrospective post-test design with comparison group | Weekly MDM at a single institution. Attended by cardiothoracic surgeon, respiratory physicians, medical oncologists, radiation oncologists, radiologist, nuclear medicine physician, pathologist, palliative care physician and lung cancer nurse | Retrospective study | Improved overall survival in MDM patients | MDM patients were more likely to have active treatment, and more likely to receive palliative radiotherapy than non-MDM patients. Non-MDM patients were more likely to receive BSC | NR | NR | NR |
| Freeman et al. (2010) USA (31) | N=1,232 Lung cancer patients, Jan 2001–Dec 2007 687 MDM patients, 535 pre-MDM (Mean prior to setup of MDM) | Retrospective pre- and post-test study | Bi-monthly MDM at a single institution attended by thoracic surgeons, respiratory physicians, medical oncologists, radiation oncologists, and a radiologist | Retrospective study | NR | Following the setup of the lung MDM, rates of curative surgery rates were unchanged apart from stage IIIA where there was an increased surgery rate; more patients received neoadjuvant chemotherapy and there were improved rates of complete preoperative staging. | Improved time from review to treatment following the establishment of the lung MDM | MDM patients were more likely to receive treatment as per NCCN Guidelines | Palliative care—MDM patients had trend to increased referral to palliative care (NS) |
| Vind et al. (2010) Australia (32) | N=335 Newly diagnosed lung cancer patients, Dec 2005–Dec 2007 | Retrospective database review. No comparison group | Weekly teleconference MDM at two institutions. Attended by cardiothoracic surgeon, respiratory physicians, medical oncologists, radiation oncologists, radiologist, nuclear medicine physician, pathologist, palliative care physician and lung cancer nurse | Retrospective study | NR | High rate of patients discussed at MDM recommended guideline treatment | NR | NR | NR |
| Boier et al. (2011) Canada (33) | N=388 NSCLC patients diagnosed, Dec 2005–Dec 2008 504 MDM patients, 484 non-MDM patients | Retrospective post-test design with comparison group | Weekly teleconference MDM at two institutions. Attended by cardiothoracic surgeon, respiratory physicians, medical oncologists, radiation oncologists, radiologist, nuclear medicine physician, pathologist, palliative care physician and lung cancer nurse | Retrospective study | MDM discussion did not impact survival | Increased rates of chemotherapy and radiotherapy for MDM patients, and equivalent rates of surgery | MDM patients had a longer time to surgery (NS), radiotherapy (NS), and palliative chemotherapy (Sig.). Equivalent time to palliative radiotherapy and curative chemotherapy in both groups | Palliative care referrals—increased referral rate in the MDM group with a longer time to referral (NS) |
| Loh et al. (2012) NZ (34) | N=161 Patients receiving radiotherapy for lung cancer, Jan–Aug 2009 110 MDM patients, 51 non-MDM patients | Retrospective post-test design with comparison group | Biweekly MDM held to cover different districts either face-to-face or video-conferenced. Both meetings were attended by thoracic surgeons, respiratory physicians, medical oncologists, radiation oncologists, radiologist, at a single institution | Retrospective study | NR | MDM patients had a longer time from diagnosis to commencing treatment | NR | NR | NR |
| Ung et al. (2016) Australia (35) | N=66 Lung cancer patients discussed at the MDM, March–May 2011 | Prospective qualitative study | No comparison group | Weekly lung cancer MDM attended by thoracic surgeons, respiratory physicians, medical oncologists, radiation oncologists, radiologist, nuclear medicine physician, nurse coordinator, and allied health at a single institution | Single institution | No comparator group Small patient numbers Short study timeframe | NR | NR | NR |

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Reference | Patient cohort and study design | Study design | Nature of multidisciplinary care | Study limitations | Survival | Treatment utilisation | Timeliness | Guideline treatment | Other outcomes
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Rogers et al. (2017) | 580 (lung cancer patients) | Retrospective pre- and post-test study | Weekly lung cancer MDM attended by surgeon, medical oncologist, radiation oncologist, pathologist and radiologist. May also be attended by allied health and GP | Retrospective study | Presentation at MDM prior to treatment associated with reduced mortality on multivariate analysis | Patients presenting at MDM were more likely to undergo active treatment, including surgery and concurrent CRT and less likely to have single modality treatment of chemotherapy or radiotherapy alone | NR | NR | NR
Stone et al. (2016) | 1,197 (Lung cancer patients diagnosed or treated, Jan 2006-Dec 2012) | Retrospective cohort study | Weekly lung cancer MDM attended by full-range of medical sub-specialties | Retrospective study | Improved survival in the MDM group at 1, 2 and 5 years for all stages, except stage IB. Improved survival in the MDM group at 5 years based on multivariate analysis | NR | NR | NR
Tamburini et al. (2018) | 477 (NSCLC patients managed with surgery, Jan 2008–Dec 2015) | Retrospective pre- and post-test audit | Weekly lung cancer MDM attended by surgeon, medical oncologist, radiation oncologist, nuclear medicine physician, pathologist, radiologist and lung cancer coordinator | Retrospective cohort | 1-year survival was significantly improved in the MDM group compared to the pre-MDM patients. MDM discussion an independent prognostic factor on multivariate analysis | MDM patients were more likely to have complete pre-surgical staging. No difference in the resection margins, postoperative complications or postoperative mortality | NR | NR | NR
Keating et al. (2010) | Cancer patients recorded with the Department of Veterans Affairs Central Cancer Registry, 2001–2004 | Retrospective audit of cancer registry | One of more MDM (tumour board), either general or lung cancer specific MDM | Retrospective audit of cancer registry | No difference in 1-year all-cause survival for NSCLC or SCLC regardless of discussion at MDM or not | Unexpected stage III patients discussed at a general MDM more likely to have radiotherapy. Patients discussed at a general or lung cancer MDM were more likely to undergo curative intent CRT for stage IA NSCLC or limited stage SCLC. There was no difference in the rates of curative surgery for stage III NSCLC, mediastinal evaluation, doublet chemotherapy for stage IV NSCLC | NR | NR | NR
Mitchell et al. (2013) | Lung cancer patients identified on a state Cancer Registry, Jan-Jun 2003 | Retrospective audit review | Multidisciplinary care model not specified | Retrospective audit of cancer registry | Overall survival significantly improved in MDM patients. Discussion at MDM independent prognostic factor | MDM patients more likely to have active treatment and twice as likely to have curative intent treatment compared to non-MDM patients | NR | NR | NR
Kahi et al. (2010) | Lung cancer patients linked to a survey of 1,601 treating oncologists, 2005–2005 | Prospective patterns of care observational study | MDM participation | Referral bias | Stage III NSCLC patients more likely to undergo curative surgery if surgeon participated in weekly lung cancer-specific MDM | Patient satisfaction—MDM discussion did not impact on patient satisfaction or patient impression of communication Clinical Trials—patients discussed at centres with weekly MDMs were more likely to be enrolled onto clinical trials | NR | NR | NR
Pan et al. (2015) | Newly diagnosed NSCLC identified from National Cancer Registry, 2005–2011 | Retrospective audit review | Hospitals participating in "Multidisciplinary Cancer Treatment Team" according to the Taiwanese “Cancer Centers for a Great Improvement in Quality of Cancer Care” initiative | Retrospective audit of cancer registry | Improved 2-year survival for all stages, NDT status predictor of survival on multivariate analysis. NDT participants (most apparent for stages II/III disease) had a significant reduction in the hazard ratio for death | Not reported | NR | NR | NR

MDC, multidisciplinary clinic; MDM, multidisciplinary meeting; NR, not reported; NSCLC, non-small cell lung cancer; SCLC, small cell lung cancer; CRT, chemoradiotherapy; QOL, quality of life; NS, not significant; sig., significant; BSC, best supportive care; GP, general practitioner.

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found improved median survival in inoperable stage NSCLC patients (92% post-MDM, P=0.006) (36). Forrest et al. conducted a retrospective review of 4,271 patients comparing patients seen in a lung cancer MDC to those not referred to the MDC (12). There was significantly improved survival for each stage at 1, 3, 5 and 10 years (apart from stage III NSCLC at 10 years). A referral bias was noted with 40% of the MDC group having stage I disease, compared to only 14% of the non-MDC group. To account for this difference, a propensity matched analysis was performed. This demonstrated significantly improved survival at 1, 3 and 5 years in the MDC patients. Stone et al. demonstrated improved survival for MDM patients at 1, 2 and 5 years for all stages, apart from stage IIIB at 1 and 2 years (35). On multivariate analysis after adjusting for age, gender, performance status, pathology, stage and year of diagnosis, MDM discussion remained a predictor of survival at 5 years (HR 0.7, 95% CI: 0.58–0.85, P<0.001). This study again had differences in the stage and performance status of the MDM and non-MDM groups. An analysis of the Taiwanese National Cancer Registry found 2-year survival for patients with NSCLC for all stages was better for patients managed through a multidisciplinary model (14). There were small but significant reduction in mortality rates in the multidisciplinary care patients with stage III and IV disease (HR 0.87, 95% CI: 0.84–0.90, P<0.001). For stage I and II patients the reduced hazard for death was not significant.

On multivariate analysis, discussion at MDM remained an independent prognostic factor for improved survival (13,15,36). After adjusting for tumour stage, comorbidities, age and treatment received patients discussed at MDM prior to treatment had reduced mortality compared to patients not discussed at the MDM, (HR 0.62, 95% CI: 0.50–0.76, P<0.01) (15). There is inconsistent evidence for the impact of multidisciplinary care on lung cancer survival. Despite many studies demonstrating a significant improvement in survival for patients managed through an MDC or MDM, these studies are limited by retrospective and varied trial design, small patient numbers and difficulties in accounting for confounding factors which impact survival in this patient.
group. However, the largest studies which have accounted for potential imbalances in prognostic factors between MDM and non-MDM groups using statistical methods, have all shown significantly improved survival in the group receiving multidisciplinary care.

Impact on treatment utilisation

The purpose of an MDM/MDC is to develop an appropriate management plan for individual patients. Several studies have evaluated the impact of an MDM on the management of lung cancer and found the MDM recommended a change in management for 39–58% of cases compared with the referring clinician’s pre-recorded management plan (34,39,40). The main reasons were to arrange further investigations, a change in the recommended treatment modality or a change in treatment intent (34,41). Adherence to implementation of the recommended management plan ranged between 26–98% (34,39,40).

Patients discussed in a multidisciplinary setting are more likely to receive active treatment including all treatment modalities (13,15,20,27,29,30). In the only randomised trial, there was no significant difference in the use of curative treatment although patient numbers were small (27). In retrospective studies, curative treatment was twice as likely to be recommended to patients discussed at an MDM (44% vs. 22%, P<0.001) (13). Stage I/II NSCLC patients were more likely to undergo curative treatment if they were discussed at an MDM (75% vs. 24%, P<0.001) (29).

In the reverse scenario, patients not discussed at the MDM were more likely to receive best supportive care only (44% vs. 58%, P=0.045) (28). This difference may reflect the fact that the non-discussed patients generally have poorer performance status, are older and have more advanced disease (10,13,35).

Patients are more likely to stay within the local system for their lung cancer treatment following the establishment of a lung MDC. Bjegovich-Weidman et al. found that 94% of patients completed their treatment at local facilities compared to 86% of lung cancer patients in the year prior to the MDC (20).

Impact on surgical utilisation

The impact of multidisciplinary care on surgical utilisation varies between studies. Three retrospective observational studies comparing surgery rates pre- and post-establishment of an MDM found that overall, discussion at an MDM did not increase the number of patients undergoing surgery (10,31,37). One cancer registry audit from a single institution found patients with stages I or II lung cancer (NSCLC and SCLC) seen in a lung MDC were 2.5 times more likely to undergo surgery (12).

Patients who were initially seen in a centre with a thoracic surgery department, were 51% more likely to undergo surgery (OR 1.51, 95% CI: 1.16–1.97) (42) and there was a 30% increase in surgery rates following the establishment of a teleconferenced MDM between a regional and tertiary referral centre (11), presumably as this provided a more direct referral pathway for patients and clinicians. Freeman et al. found that despite equivalent rates of curative surgery overall regardless of whether a patient was reviewed in the MDM but there was an increase in the proportion of patients with stage IIIA NSCLC undergoing surgery (89% vs. 49%, P=0.0079) (31). Regular attendance at the MDM was also associated with an increased rate of surgery for patients with stage I/II lung cancer (OR 2.9: 95% CI: 1.3–6.8) (38).

There was an improvement in completeness in staging for newly diagnosed lung cancer following the establishment of an MDM (31). In two retrospective observational studies more patients underwent mediastinal staging prior to surgery if reviewed in an MDM (24,36). However, in a review of the Department of Veterans Affairs Central Cancer Registry, multidisciplinary care did not impact the rates of mediastinal evaluation (37). There were fewer patients with pathological N2 disease following surgery if their cases were reviewed in an MDM, perhaps reflecting improved pre-operative staging, however surgical margin status was unchanged (31).

Overall, multidisciplinary case discussion may increase rates of surgery for stage I and II NSCLC, especially if the patient is reviewed in an MDC setting with access to thoracic surgery or if there is an established referral pathway for thoracic surgeon review.

Impact on radiotherapy utilisation

Boxer et al. found that radiotherapy utilisation was doubled if patients were discussed at an MDM (66% vs. 33%, P<0.001) (10). Two retrospective pre- and post-studies separated radiotherapy into curative and palliative treatment (26,28). These studies found a differing effect of MDM discussion. Forrest et al. showed similar rates of curative or palliative radiotherapy in patients with inoperable NSCLC before and after the establishment of an MDM (28),
although the total number of patients, especially those receiving curative radiotherapy was small. Price et al. found a significant increase in the rate of curative radiotherapy in elderly patients (3% to 12%, P=0.004) after establishing an MDM and a corresponding fall in the rates of palliative thoracic radiotherapy (65% to 55%) (26).

An analysis of the Department of Veterans Affairs Central Cancer Registry compared radiotherapy utilisation for unresected stage I/II NSCLC, stage IIIA NSCLC and for limited stage SCLC based on presentation at a lung cancer specific MDM, a general MDM or no MDM discussion (37). Discussion at a general MDM resulted in an increase in radiotherapy for unresected stage I or II NSCLC, (70.8% vs. 66.5%, P=0.04). Similarly, patients were significantly more likely to undergo concurrent chemoradiotherapy for stage IIIA NSCLC or limited stage SCLC if they were discussed in an MDM (either lung cancer specific or general MDM) compared to those patients not discussed at an MDM.

On multivariate analysis, discussion at MDM as well as age and tumour stage were independent predictors of treatment modality (10). Despite limitations in the studies, overall, MDM discussion leads to more patients receiving radiotherapy, both curative and palliative.

**Impact on chemotherapy utilisation**

For lung cancer patients overall, discussion at an MDM resulted in more patients being recommended chemotherapy (10,28,31) and specifically neoadjuvant chemotherapy (31). There was no difference in adjuvant chemotherapy usage for stage IIIA disease (37). The majority of patients referred for chemotherapy had inoperable stage III (28) or stage IV disease (28,31) and there was no difference in the proportion of patients receiving chemotherapy in stages IIIB or earlier stage disease (31). Murray et al. demonstrated a similar trend, with patients randomised to the central MDC arm twice as likely to receive chemotherapy (44% vs. 23%, P=0.03) the majority being with palliative intent (27), although the patient numbers in this study were small. A review of cancer registry data demonstrated a non-significant improvement in the rates of doublet chemotherapy for patients with stage IV disease who were discussed at an MDM (37).

Multidisciplinary care of lung cancer patients is likely to be associated with an increase in the recommendation for chemotherapy overall. The timeframe for all trials published to date was prior to the use of targeted therapies or immunotherapy, therefore this was not assessed at an outcome of multidisciplinary care.

**Impact on guideline treatment**

There are a number of evidence-based clinical practice guidelines for the management of lung cancer (1,2,4,5), which help with decisions regarding treatment pathways. The impact of a multidisciplinary discussion on guideline treatment has been addressed in several studies (24,31,32). These all found greater adherence to guideline management for patients discussed in a multidisciplinary setting. A significantly greater proportion of patients with stage III NSCLC who were assessed in an MDC were managed as per hospital guidelines (89% vs. 35%, P<0.001) (24). For lung cancer patients of all stages, treatment was recommended in concordance with NCCN Guidelines in 97% after a MDM was established compared to 81% before (31).

Vinod et al. found 71% of management plans discussed at the lung MDM were concordant with guideline treatment (32). This varied according to treatment modality, 88% for guideline radiotherapy, 77% for guideline chemotherapy and 58% for guideline surgery. Reasons for not offering guideline therapy included physician decision, comorbidity, and technical factors that precluded the safe delivery of radiotherapy (32).

Despite the limitations of these studies, including their retrospective single institution design and potential referral bias, overall, multidisciplinary care of lung cancer patients results in recommendations consistent with evidence-based treatment guidelines and greater adherence to guideline-based treatment.

**Impact on timeliness of care**

Timeliness of care is important in the management of lung cancer as longer time to commencing treatment is associated with the potential for disease progression as demonstrated on several studies which have performed serial positron emission tomography (PET) scans (43-45). Multiple different measures of timeliness of care have been evaluated, including the time from diagnosis to treatment (10,17,19,20,24,27,31,33), time from MDM or MDC to treatment (6,21,24,25,27,30), time between referral and clinic review (17), and the time from first visit to diagnosis (17).

The impact of a multidisciplinary approach for the time to treatment varies across the studies. Seven studies noted an improvement in the time to treatment for patients seen
in an MDC (16,19-21,25,27,31). Two studies found no change in time from diagnosis to treatment, either from radiological diagnosis (24) or endobronchial ultrasound (EBUS) (17), and another two studies found a non-significant longer time from diagnosis to treatment for patients presented at MDMs (10,33). For patients reviewed in an MDC, the average time from first clinic appointment to the start of treatment was improved for stage III NSCLC patients (19.9 vs. 27.3 days, P=0.04) (24).

In general, the studies showing an improved time between diagnosis and commencing treatment were those which involved an MDC, where patients are reviewed in a single clinic by the relevant specialists and a management plan is decided at time of the clinic review (16,19-21,25,27,31). In contrast two studies evaluating MDM discussion both found a longer (albeit non-significant) time between diagnosis and treatment (10,33). This may reflect the time taken between discussion at the MDM and assessment in a subsequent clinic to discuss treatment with the patient (33).

The impact of an MDC in terms of time to diagnosis and time to treatment was maintained even after the MDC was ceased, with continuation of an MDM or case conference (17). The median time to treatment was 21 days for patients seen in the MDC and 23 days for patients who were managed in the timeframe after the MDC was no longer functioning (P=0.38). Similarly, the median time to diagnosis was unchanged, 45 vs. 47 days.

The time to commencing specific treatment modalities was examined in three (10,11,33) studies. There was a non-significant reduction in time from diagnosis to surgery in patients discussed at MDM (10,11,33). There was an increase in the time to commencing radiotherapy (10,33) or chemotherapy (10) in those discussed at MDM, only the time to starting palliative chemotherapy was significant (10). An increased time from referral to a clinic appointment with the oncologist may account for this difference (33).

For patients seen in an MDC the average time between a decision for active treatment to commencing therapy was less than timeframes recommended by guidelines (18). Ninety-one percent of patients underwent surgery earlier than 6 weeks post MDC and no patients waited longer than the guideline recommendation of 8 weeks. Boxer et al. and Freeman et al. both found that regardless of whether patients were discussed in a multidisciplinary setting or not, the time from diagnosis to surgery met this 8-week recommendation (10,31). The time from diagnosis to surgery for patients discussed and not discussed at the MDM was 6 and 7.1 weeks respectively in the Boxer et al. study (10) and 2.4 and 3 weeks respectively in the Freeman et al. study (31).

The mean time for patients reviewed in an MDC to commencing radiotherapy was shorter than recommended in guidelines (18), with the time to definitive radiotherapy 22 days (guidelines ≤28 days) and to palliative radiotherapy was 8.4 days (guidelines ≤14 days). Other studies have shown slightly longer times to the commencement of radiotherapy (intent not specified), 27 days (6) and 31 days (33).

The utility of timeliness of care to measure the impact of multidisciplinary care is not straightforward. Intuitively, a shorter time between diagnosis and treatment would reduce the risk of disease progression in early stage disease (43-45). However, timeliness of care and patient survival have been shown to have an inverse relationship. Patients who are symptomatic or have advanced disease may commence palliative radiotherapy, which tends to be a simpler technique in a shorter timeframe than for curative treatments which require a longer time for planning (46). In stage III and IV NSCLC there was improved survival associated with a shorter time from diagnosis to treatment, but no association between shorter time to treatment and survival benefit in early stage NSCLC (47).

Overall, the impact of multidisciplinary care on timeliness of care is difficult to assess as there is a wide variation in time intervals measured and most studies do not distinguish between different treatment modalities, nor treatment intent. Patients seen in an MDC setting appear to have shorter times to treatment commencement.

**Impact on palliative care referrals**

The importance of early referral to palliative care in patients with stage IV NSCLC has been demonstrated in a randomised controlled trial where early palliative care review was associated with a 2.3-month improvement in median survival as well as QOL (48). The impact of lung cancer multidisciplinary care on palliative care referrals is mixed. Stone et al. found no difference in the proportion of patients with stage IV lung cancer patients referred to palliative care services regardless of discussion at MDM or not (35). Boxer et al. found a greater proportion of patients who were discussed at the MDM were referred to palliative care (10). This difference was significant and discussion at the MDM was an independent predictor of palliative care referral. A third study found an increased proportion of patients in the MDM group who were
referred to palliative or hospice care, although this difference was not significant (31).

In an MDC setting, all patients requiring palliative care review were seen by the palliative care service compared to only 88% of patients prior to establishing the clinic (21). Patients identified a number of advantages in co-locating palliative care services within an MDC, including improved service provision, reduction in referral times, reduced transport costs and a smooth transition between services (22).

It should also be noted that patients who were discussed at an MDM had a longer time to referral to palliative care (10,35). The differences in the time to palliative care referrals may reflect the fact that patients discussed in the multidisciplinary setting tend to have earlier stage disease, be younger, better performance status (10,12-16,35), and are more likely to receive active treatment (13,15,30).

Impact on QOL

QOL as measured by the EORTC QLQ-30 was determined for patients randomised to the centralised MDC and local care at baseline and 6 weeks (27). Overall QOL was no different between the two arms, although there was a significant reduction in certain domains (role, social and financial function) in the centralised MDC arm at 6 weeks. At the 6-week mark, 44% of the MDC group had commenced chemotherapy, compared to 23% in the locally treated group. Treatment-related side-effects may account for the differences in QOL seen between the two groups.

High levels of distress have been recorded in lung cancer patients (49). In addition, patient-related QOL has been demonstrated to be an independent prognostic factor in patients with advanced lung cancer (50). However, few studies have examined the impact of multidisciplinary care on QOL in lung cancer or other cancers. Multidisciplinary assessment may provide an opportunity to assess patient’s QOL and to screen for distress and psychosocial concerns and provide rapid referral pathways to appropriate services. The effectiveness of this referral process is related to the participating members of the multidisciplinary team.

Impact on clinical trial enrolment

The impact of multidisciplinary care on clinical trial enrolment has not been extensively investigated and the evidence is conflicting. Riedel et al. found lung cancer patients who were seen in the MDC were more likely to be enrolled on a clinical trial (55 patients) compared to patients who were not seen in the clinic (6 patients) (17). Freeman et al. found a non-significant increase in the proportion of patients on clinical trial for the MDM group (11% vs. 7%, P=0.07) (31). Both studies are limited by small sample size and retrospective study design.

Discussion

The diagnosis and management lung cancer are complex and management may involve utilisation of multiple treatment modalities including thoracic surgery, systemic therapy, radiation therapy and palliative care. A multidisciplinary care model, either in the form of an MDC or MDM, allows for the review and discussion of individual patient cases in order to determine an appropriate management plan in a patient-centred and structured format.

The impact of multidisciplinary care in lung cancer has been extensively studied with a wide range of outcomes reported. The available evidence is limited by the lack of high-quality evidence with only a single small randomised
controlled trial reporting the impact of a lung cancer MDC model on patient outcomes (17). The remaining evidence is from mostly retrospective reviews comparing outcomes pre- and post-MDC/MDM establishment or patients discussed in the multidisciplinary setting vs. patients managed outside of the multidisciplinary environment. These trials use differing methods, definitions and outcome measures, making it difficult to make any direct comparisons. In addition, there are a multitude of confounders present such as heterogeneity of tumour stage, performance status, comorbidities, socioeconomic status and access to services which impact on the significance of the findings in the studies.

Despite these limitations, multidisciplinary care does appear to have a positive impact on a number of outcomes in lung cancer. In the larger cohort trials which accounted for potential confounding factors, there was a significant improvement in survival for patients managed in a multidisciplinary setting. Multidisciplinary care was also associated with higher rates of active treatment overall and increased utilisation of surgery, chemotherapy and both curative and palliative radiotherapy. This improvement in active treatment should be considered in the context of a potential referral bias, as patients who are referred for multidisciplinary care are more likely to be younger, have better performance status, fewer comorbidities and have earlier stage disease. In fact, it is important to discuss the cohort of older patients with comorbidities as multidisciplinary input is necessary to determine fitness for curative treatment particularly if multimodality treatment is being considered.

Multidisciplinary care was associated with improved adherence to guideline management, resulting in more patients being recommended to receive a treatment recommendation based on the best available evidence. Rates of concordance between the multidisciplinary recommendations and treatment delivered varies between 63–96% (6,33,51). Concordant clinical management is important as it has been shown to be significantly associated with improved median and progression free survival (51).

Despite being a reported outcome in many studies, the impact of multidisciplinary care on the timeliness of care in lung cancer is difficult to assess due to the wide variety of time intervals measured in the different studies. An MDC model of care is likely to have a shorter time from review to treatment commencement.

Access to palliative care services is improved when there is a well-defined referral pathway, for instance the colocation of palliative care physicians within the MDC allows for all patients needing input from the palliative care service to be seen in a timely fashion (21,22). MDM discussion may not have an impact on the rate of palliative care referrals and the time to palliative care referral was longer for the MDM patients, reflecting the increased rate of active treatment in this group of patients.

Other outcomes such as patient QOL, patient satisfaction and enrolment on clinical trials have been assessed in only a few studies which have significant limitations. There was no clear evidence reported to suggest that multidisciplinary care improved patient’s QOL or clinical trial enrolment. Overall patients appear to be satisfied with an MDC model of care, although some patients reported finding the MDC confusing (23) and did not like the repetition of their history and examination when seen by multiple practitioners within the clinic (21). These findings suggest the need to optimise the structure of the multidisciplinary care model. Having a care coordinator as a point of contact, to help navigate patients through the MDC, or to ensure appropriate follow-up is made following MDM discussion has been demonstrated to help address these issues (19).

A potential benefit of multidisciplinary care is improved health care utilisation and a reduction in the financial cost to the patient. Following the establishment of an MDC, there was a reduction in the financial cost to patients, particularly in a reduction in the cost of diagnostic investigations as well as fewer provider visits (16). Multidisciplinary care is also associated with patients having fewer visits to their general practitioner during their workup and treatment (27).

Areas for further assessment of the benefit of multidisciplinary care should be done in a prospective manner ideally across multiple institutions. Given many institutions have well established multidisciplinary processes it would be difficult to randomise patients to not receive this care. However large patient cohort studies could potentially further review the impact on treatment utilisation and survival if all prognostic factors are documented and accounted for in analysis. Other potential outcomes of multidisciplinary care in lung cancer which could be further investigated include assessment of the impact on QOL and patient reported outcomes, the benefits of screening in high risk populations and the utilisation of the newer systemic therapies including targeted therapies and immunotherapies.
Conclusions

Despite the limitations in the quality of evidence available, multidisciplinary care in lung cancer is associated with improvements in patient outcomes, in particular improved survival, improved utilisation of all treatment modalities, and adherence to guideline management, thus supporting the recommendations of a multidisciplinary approach to lung cancer care.

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Footnote

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