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IN REGARD TO KAGAN: "THE MULTIDISCIPLINARY CLINIC" (*INT J RADIAT ONCOL BIOL PHYS* 2005;61:967–968)

To the Editor: We read with great interest the article by Robert Kagan (1) regarding the multidisciplinary approach to cancer patients. It is a matter of fact that not only do patients suffer from the diagnosis of cancer, but they can also be completely disoriented by the various, often opposite, recommendations they have received from different physicians. Most of the time, a patient's first reaction to the diagnosis of cancer is refusal and anger. On the other hand, patients are willing to examine all of the possible therapeutic approaches available to have their cancer problem solved as soon as possible. Although surprising in our era of globalization, looking for optimal treatment sometimes disorients rather than orients the patient in deciding what to do.

These issues are particularly relevant for prostate cancer patients and constitute the basis for promoting a multidisciplinary clinic. It is well recognized that there is no unique evidence-based optimal treatment for prostate cancer (2). The possible radical strategies (i.e., surgery, external radiation, brachytherapy) show only slightly different disease control rates. Furthermore, in selected cases, watchful waiting and active surveillance should also be taken into consideration in this scenario. As a consequence, difficulties can be experienced by both clinicians and patients who have to choose the "best" approach. On this basis, one patient affected by prostate cancer is likely to consult several specialists (urologist, radiation oncologist, and medical oncologist); he collects varying information and recommendations during the consultations and independently tries to figure out his own scenario and to consciously choose his own way.

In the attempt to resolve this fragmented approach to prostate cancer, Milan National Cancer Institute decided to offer the prostate cancer patient a multidisciplinary approach with a team of urologists, radiation oncologists, medical oncologists, and psychologists. Our multidisciplinary clinic is organized in three phases that take place in one morning. The patient with a diagnosed prostate cancer first meets a urologist or a radiation oncologist, who takes the patient's history, performs a physical examination, and studies and records staging exams. Afterward, the multidisciplinary team meets to discuss each single case and considers the potential recommended therapies and the possible alternatives. Lastly, the multidisciplinary group in plenary session informs the patient of the best therapeutic option(s) and offers him explanations regarding therapies and side effects.

As clearly indicated also by Dr. Kagan, we have decided to adopt this format to reduce the risk that the patient should receive opposite recommendations.

Furthermore, we would like to take advantage of the practical experience of each specialist, together with the common knowledge that the multidisciplinary clinic assembles. This practice is meant to enable the specialists to offer the patient detailed and satisfactory explanations and to resolve the disorientating effect and loss of emotional control that often follow the diagnosis of cancer. Moreover, complex as well as borderline clinical cases, often passed between different specialists, could receive a univocal recommendation in the multidisciplinary clinic.

Because in most cases a single specialist is apt to give an ambiguous indication, the patient affected by prostate cancer is frequently compelled to face the responsibility of choosing his therapy among the therapies proposed. The patient needs therefore to take into consideration his values and personal preferences, as well as the capacity to cope with the stress caused by the diagnosis of cancer. Furthermore, he absolutely needs to be informed about the various potential side effects (e.g. incontinence after surgery, proctitis after radiation therapy or brachytherapy, erectile dysfunction for all three) (3), and on this basis he can make a decision. In this scenario, the multidisciplinary clinic becomes the first necessary step in the process of decision-making, which cannot be exhausted in a single moment (4).

As noted by Davison *et al.* (5), and also in our experience, patients express the wish/need to take part actively in the process of decisionmaking. The patient is accompanied in this process by the different specialists, with the psychologist offering counseling. We have chosen to have a psychologist in the multidisciplinary team to offer the cancer patient a holistic approach to the disease in the attempt to consider the whole patient and to deal with the complexity of experiencing this disease in all its organic and emotional aspects. As a multidisciplinary group, we care for the patient's well-being, and we listen to and respect his requests, doubts, and difficulties. The feeling of being holistically taken care of can often be one of the most important messages the patient takes home.

Besides the pros of working in a team, it is absolutely necessary to underline the risks of such a format. It is not true that different specialists together in the same room automatically act like a working team, as originally underlined many years ago by Bion (6). In this perspective, the risk is to waste human resources, to adapt the group's opinion to the dominating physician's thought, and to delegate to the group the individual clinician's responsibility.

To solve part of these potential problems from a technical point of view, we have chosen to adopt intrainstitutional guidelines that contribute to creating the previously shared basis for discussing single cases. From a psychological point of view, we have considered it important to organize meetings to reflect on the multidisciplinarity itself and to discuss our way of working together and our capability of sharing the group's experience and know-how. We strongly believe that the multidisciplinary format needs

to be created, organized, and built outside the visiting room and far from the patient, in the weekly clinical case discussions and in meetings focused on the analysis of our behavior. During these meetings, every specialist can "practice" working in team procedure, learn to discuss his own opinion, and experience the other specialists as a resource rather than as a limitation to his own freedom. The more the group is willing to accept the different voices emerging from the multidisciplinary clinic, the more it will be able to listen to the patient's voice.

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