Original Article

Patients' perspective of one-stop breast clinic, Lagos University Teaching Hospital

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Abstract

Introduction: The complex nature of cancer diagnosis and treatment, with the pressing need for individualized patient care, has led to the services being organized into multidisciplinary teams (MDTs), also called tumor boards or cancer conferences. MDTs are beneficial as they provide coordinated, consistent, expert-driven, and cost-effective care that is delivered in a timely fashion to the patient. This study is aimed to assess the level of impact of a one-stop breast clinic on the management of breast cancer among breast cancer patients in Lagos University Teaching Hospital (LUTH).

Methodology: A cross-sectional descriptive study was carried out among patients who attended the MDT breast clinic on referral from within and outside Lagos University Teaching Hospital LUTH.

Results: The mean age ± standard deviation of the respondents was of 33.4 ± 7.62 years. More than half of the respondents (66%) felt satisfied about the workings of the MDT clinic, with less than a quarter of respondents reporting that were very satisfied with the clinic. Almost all the respondents (90%) were of the view that it allowed for a more expert opinion. Problems faced by the clinic in the MDT Clinic included filled up booking times (6%) and not taking enough time to attend to patients (2% each).

Conclusion: The study revealed a good level of satisfaction among respondents about the MDT clinic; however, reservation on issues such as booking time, better patient to doctor relationship, and availability of more doctors were still of concern to patients. Addressing these issues are vital in achieving an all-round great experience in the multidisciplinary setting.

Keywords: Breast cancer, Lagos university teaching hospital, multidisciplinary team

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INTRODUCTION

Over the past two decades, significant advances have been made in the diagnosis and management of breast cancer due to an augmentation in knowledge about the biology and molecular changes in breast cancer. Extensive profiling at the molecular level has led to understanding of breast

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cancer as a heterogeneous disease and not a single entity, thus facilitating the development of personalized medicine such as targeted therapies like trastuzumab used in cases of HER2-positive cancers, which are ultimately more sophisticated than previously available treatment.[1]

The complex nature of cancer diagnosis and management, with the pressing need for individualized patient care, has led to the organization of multidisciplinary teams (MDTs), also called tumor boards or cancer conferences.[2]

The UK Department of Health defines MDT as "a group of people of different healthcare disciplines that meets together at regular intervals a given time (whether physically in one place or by video or teleconferencing) to discuss a given patient, and who are each able to contribute independently to the diagnostic and treatment decisions about the patient."[2] The Lagos University Teaching Hospital (LUTH) MDT consists of surgeons, oncologists, radiologists, histopathologists, psychiatrists, nurses, and other allied health professionals. MDTs are being adopted as the standard of care for cancer patients worldwide, with the UK making it compulsory to treat cancer patients with specialist MDTs.[3]

Effective MDTs have been shown to be associated with a range of benefits such as improved clinical decision-making, adhering to guidelines, recruitment to clinical trials and research, and training of personnel; better clinical outcomes including survival and health professional satisfaction in multiple observational and quasi-experimental studies.[4] Therefore, MDTs are beneficial as they provide coordinated, consistent, expert-driven, and cost-effective care that is timely delivered to patients.

Before the introduction of MDTs in breast cancer management, patients were referred from one clinician to another at various stages of diagnosis and treatment with an integrated approach to management, which can be quite an overwhelming experience on the part of the patient and resulting in unorganized patient care on the part of the caregivers,[5,6] so this study aimed to assess the level of impact of one-stop breast clinic on management of breast cancer among breast cancer patients in LUTH.

METHODOLOGY

Study setting

The study was conducted at the MDT Breast Clinic of the LUTH, Idi-Araba, Lagos. The hospital is one of the two tertiary centers that provide specialized cancer care in Lagos and therefore receives cancer referrals from the south-western part of Nigeria, as well as the rest of the country and neighboring countries.

The Breast Clinic in LUTH is a one-stop breast clinic which serves as a point of convergence for patients with referrals pertaining to benign and malignant breast diseases. The clinic thus brings together experts involved in cancer management for clinician opinion and decisions.

Study design

A descriptive cross-sectional study was carried out among patients who attended the MDT breast clinic on referral from within and outside the LUTH.

Study population

This included all patients (i.e., 50 women) who attended the MDT breast clinic over a period of 6 months and consented to filling the questionnaire failure to give consent was the exclusion criteria employed.

Sampling method

The sampling methodology used was convenience sampling by using attendants at the clinic during the study period.

Study instrument

Data collection was carried out using a self-administered questionnaire distributed in the clinic. The questionnaire had three sections on demographics, patient responses to questions on the way the clinic is run, and a last section on patient's opinions to improving quality of service.

Data analysis

Data obtained from respondents in this study were analyzed using the Statistical Package for the Social Sciences (SPSS) version 22 (IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp). Univariate analysis was presented in the form of frequencies and tables.

Ethical approval

Ethical approval was obtained from LUTH Health Research Ethics Committee, with assigned no ADM/DCST/HREC/1660.

RESULTS

The sociodemographic characteristics of the 50 respondents who participated in the study showed that respondents were mostly between the ages of 31to 40 years (16, 32%) with the mean age ± standard deviation of 33.4 ± 7.62 years. Majority of respondents (29, 58%) were married and about a quarter (21, 24%) were nulliparous [Table 1a and b]. Twenty-four (48%) were referred from outside LUTH

and most of them had presented for the first time within the past 3 months (<1 month and 1–3 months) before the study (31, 62%) and only 22% (11 respondents) had done so for >6 months [Table 1].

Half of the respondents (25, 50%) felt satisfied about the workings of the MDT clinic, with less than a quarter of respondents (10, 20%) reporting that were very satisfied with the clinic. Over half of the respondents (30, 60%) reported satisfaction as regards the waiting time. Similarly, the services of doctors received a good rating, as 66% (33 respondents) of respondents were satisfied with the services rendered by the health professionals [Table 2].

About 92% (46 respondents) of respondents were in agreement about the more coordinated nature of the MDT clinic. Majority of participants (40, 80%) also believed the clinic affected patient care positively. Almost all the respondents (44, 88%) were of the view that it allowed for evidenced-based treatment decisions while another 72% (36 respondents) believed it cut down the cost of care. Perception of care was seen to be better by 74% (37 respondents) of the patients.

As regards an assessment between the time of diagnosis and initiation of treatment, 64% (32 respondents) of respondents were of the opinion that it reduced the time between diagnosis and initiation of treatment. A good number of patients (40, 80%) were also of the view that MDTs should be a mandatory part of cancer care.

About half of the respondents (52%/26 respondents) were of the view that MDT members should get more training, and 40 (80%) of respondents believed that the clinic improved the overall quality of treatment. Forty (80%) also agreed that the MDT clinic allowed for an improved level of patient involvement in treatment decisions while thirty-eight (76%) believes it improved survival rate.

Problems faced by the patients in the MDT Clinic included filled up booking times (3.6%), contradictory view of the various teams, the lateness of the team members, inadequate consultation time, nonchalant attitude to clients conditions (1.2% each), while 18% (9 respondents) did not report any problem with the clinic at all

The caring attitude and hospitality of the team member, good relationship with patients, good organization, fast track treatment process, cordial relationship, and access to the health information were some of the things the clients enjoyed about the clinic. Most respondents (32, 64%) stated that they preferred the MDT style of the clinic, 14% (7 respondents) preferred the solitary SOP clinic and another 22% (11 respondents) were undecided.

Two percent of the respondent respondents believed an improved quality of service could be achieved through early arrival and more coordinated care; other factors suggested includes the regular availability of consultants at all clinics,

Table 1a: Socio-demographic characteristics of respondents

	Frequency (*n*=50), *n* (%)
Age	
<20	3 (6.0)
21–30	15 (30.0)
31–40	16 (32.0)
41–50	13 (26.0)
>50	3 (6.0)
Marital status	
Single	20 (40.0)
Married	29 (58.0)
Divorced	1 (2.0)
Education	
Primary	7 (14.0)
Secondary	19 (38.0)
Tertiary	24 (48.0)

Table 1b: Sources of referral and duration of attendance

	Frequency (*n*=50), *n* (%)
Place of referral	
Within LUTH	26 (52.0)
Outside LUTH	24 (48.0)
Duration of attending breast clinic	
<1	13 (26.0)
1–3	18 (36.0)
4–6	8 (16.0)
7–12	2 (4.0)
>12	9 (18.0)

LUTH – Lagos University Teaching Hospital

Table 2a: Respondents' perspective of one-stop breast clinic

	Frequency (*n*=50), *n* (%)
Waiting time	
1–3 months	18 (36.0)
3–6 months	81 (6.0)
6–12 months	2 (4.0)
<1 month	13 (26.0)
More than 1 year	9 (18.0)
Patient input	
Don't know	5 (10.0)
Not satisfied	7 (14.0)
Satisfied	25 (50.0)
Somewhat satisfied	10 (20.0)
Very satisfied	3 (6.0)
MDT satisfaction	
Very satisfied	10 (20.0)
Somewhat satisfied	8 (16.0)
Satisfied	25 (50.0)
Not satisfied	5 (10.0)
Don't know	2 (4.0)
Arrival time	
Don't know	3 (6.0)
Not satisfied	17 (34.0)
Satisfied	23 (46.0)
Somewhat satisfied	7 (14.0)

MDT – Multidisciplinary teams

Table 2b: Respondents' perspective of one-stop breast clinic

	Frequency (*n*=50), *n* (%)
More coordinated patient care	A
Agree	28 (56.0)
Indifferent	4 (8.0)
Strongly agree	18 (36.0)
Grand total	50 (100.0)
Positively affected patient care	B
Agree	24 (48.0)
Don't agree	1 (2.0)
Indifferent	9 (18.0)
Strongly agree	16 (32.0)
Grand total	50 (100.0)
Evidence based treatment decision	C
Agree	28 (56.0)
Indifferent	6 (12.0)
Strongly agree	16 (32.0)
Grand total	50 (100.0)
Reduce cost of care	D
Agree	18 (36.0)
Don't agree	1 (2.0)
Indifferent	13 (26.0)
Strongly agree	18 (36.0)
Grand total	50 (100.0)
Improve perception of care	E
Agree	22 (44.0)
Don't agree	2 (4.0)
Indifferent	11 (22.0)
Strongly agree	15 (30.0)
Grand total	50 (100.0)
Reduce time between diagnosis and initiation of treatment	F
Agree	15 (30.0)
Don't agree	8 (16.0)
Indifferent	10 (20.0)
Strongly agree	17 (34.0)
Grand total	50 (100.0)
Should be a mandatory part of cancer care	G
Agree	21 (42.0)
Don't agree	2 (4.0)
Indifferent	8 (16.0)
Strongly agree	19 (38.0)
Grand total	50 (100.0)
MDT member should receive more training than available currently	H
Agree	16 (32.0)
Don't agree	1 (2.0)
Indifferent	23 (46.0)
Strongly agree	10 (20.0)
Grand total	50 (100.0)
Improved clinical decision making	I
Agree	33 (33.0)
Indifferent	8 (8.0)
Strongly agree	9 (9.0)
Grand total	50 (50.0)
Total	100 (100.0)
Improved overall quality of treatment	J
Agree	29 (58.0)
Don't agree	1 (2.0)
Indifferent	9 (18.0)
Strongly agree	11 (22.0)
Grand total	50 (100.0)
Improved patient involvement in treatment decision	K
Agree	20 (40.0)
Indifferent	10 (20.0)
Strongly agree	20 (40.0)
Grand total	50 (100.0)
Improve survival rate	L
Agree	21 (42.0)
Indifferent	9 (18.0)
Strongly agree	17 (34.0)
Strongly disagree	3 (6.0)
Grand total	50 (100.0)

MDT – Multidisciplinary teams

continuity in the treatment process, increased clinic time to more than once in a week, more interactive sessions and counseling to ease the anxiety of patients [Table 2].

DISCUSSION

This study assessed the level of impact of a one-stop breast clinic on the management of breast cancer among breast cancer patients in a tertiary health facility in Lagos, Nigeria. Over the years, the use of MDTs is virtually nonexistent in Nigeria and this one-stop breast clinic is one of the leading few organized MDT structures in the. Nigeria.[5,6] Findings from the current study generally revealed a good opinion about the impact of the one-stop breast clinic on breast cancer patients, as was reported in studies by Taylor *et al*. and Kesson *et al*.[1,4,7]

Over the years, the positive intervention by the MDT mode of management has been buttressed by reports from a number of studies done years ago. A comparative cohort study which evaluated patients with breast cancer following the formal introduction of MDT care by the Greater Glasgow Health Board in 1995 had the nonintervention area continue to deliver care using traditional models. Breast cancer mortality was 11% higher in the intervention area than in the nonintervention area with comparable all-cause mortality before the introduction of MDT based care.[7] In another study, following the introduction of MDT-based care in the intervention area, breast cancer mortality got reduced by 18% and all-cause mortality was 11% lower at 5 years in comparison to the nonintervention area.[8]

Findings in the current study as regards satisfaction with the working of the MDT showed that 86% of the patients were very satisfied/satisfied. These findings were quite similar to those of Sadjadian in an Iranian study where 82% of respondents stated that they were either very satisfied/satisfied, 4% were dissatisfied. While it is important to note that most respondents had a high level of satisfaction with the MDT services, one factor that might have been responsible for this is the fact that there are limited numbers of one-stop breast clinics organized in a multidisciplinary approach nationwide.[8] The presence of a generous number of these kinds of clinics could have

created more room for comparative analysis. The Iranian study by Sajadian also reported that the level of satisfaction seen among their respondents could have had some cultural factors attached to it as Iranians are not so critical with the appraisal of services.[8] This characteristic of cultural behavior could be said to be present among Nigerians and their views on services too.

Three-quarters of the patients (76%) stated that they were very satisfied/satisfied with their level of involvement as regards making decisions in their management in this study. These findings have been corroborated in a previous study where 84% of patients were satisfied with the information provided by their physicians and 73% stating that their questions had been answered.[9] However, only about 34% of respondents stated that somewhat/not satisfied with the MDT services; this trend seems to be changing gradually as patient management moves toward patient-centered care in today's world.

The current study revealed a high level of positive opinions on the impact of MDT from patients with regard to coordinated care (92%), reduction in the cost of care (72%), reduction in time between diagnosis and treatment (64%), improved clinical decision-making (42%) and patient involvement in treatment decision (80%). A pilot study by Choy *et al*. done in Australia, which aimed to assess the feasibility and acceptability of involving patients diagnosed with breast cancer in multidisciplinary discussions and treatment planning also found most of their respondents stating positive views about it.[10]

There was also a positive opinion by patients that MDT should be made compulsory in cancer care as recommended by 80% of the respondents in this study, and this is similar to what obtains in the UK where MDTs are mandatory in cancer care.[11]

While Choy *et al*. found that most of their respondents majorly complained about an increased level of anxiety (31%), the overwhelming nature of the meeting as it relates to having a large number of people in the room (23%) and an increased level of confusion (9%); the challenges faced by respondents in our current study included overfilled booking times, and delays in getting appointments or ample consulting time, occasional contradictory opinions of the team. Although it is vital to state that the number of respondents in the current study may not be representative enough of the wider population, a disparity as regards the kinds of responses in studies may possibly be due to a shortage of Doctors and other health care givers in Nigeria. The WHO estimated four doctors to 10,000 populations in Nigeria, leading to a lack of access to quality care in Nigeria of the few ones on the ground and resulting delay in assessing quality medica; care when compared to developed countries.[12]

A study in the UK which assessed the attitudes to and experiences of patients with cholangiocarcinoma as regards the MDT process through a simple questionnaire using social media platform found that despite the low number of queries as regards treatment decisions, there were other reservations. These were as regards lack of communication, lack of involvement and not knowing who to approach for answers to some questions the patient's had.[13] Although these themes did not take the bulk of complaints in the current study, there were a few reservations as regards the interaction between doctor and patients.

It was a source of concern to respondents in the current study that the health workers should get more training and be more empathetic to patients' plight. This has been advocated for in past research with some studies calling for training in nontechnical skills to be imbibed.[14] In addition to this, due to the changing medical culture, there has also been a clamor for decision aids to encourage active participation of patients in decision-making and a regular assessment of shared decision-making to create accountability.

CONCLUSION

Before this study, there had rarely being any studies that assessed the efficacy and impact of a one-stop clinic in the management of cancers and chronic diseases in this part of the world, to the best of our knowledge. Despite being one of the few studies that have evaluated the overall impact of the MDT as a new development in cancer management, the study found a good level of satisfaction among respondents about the MDT clinic; however, reservations on issues such as shortage of health-care providers, delays getting appointment time, improved patient to doctor relationship and training of staff on other supportive skills were still of concern to patients. Addressing these issues are vital in achieving an excellent experience in the multidisciplinary setting.

Limitations

We acknowledge the limitations of this study. The total number of respondents in this study may not be fully representative of the opinions of patients in an MDT setting in a developing country. Furthermore, results from a one-center study would also not be representative enough to conclusions.

Recommendations

We, therefore, recommend more robust studies done involving more than one center while also utilizing a larger number of respondents done in this part of the world to make better conclusions. More so, a study done in a focused group discussion manner would reveal even more thorough findings than closed-ended questions utilized in this study.

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Conflicts of interest

There are no conflicts of interest.

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QUESTIONNAIRE

Impact of one-stop breast clinic on breast cancer patient in LUTH

Please tick the boxes and fill in the blank spaces as appropriate.

Section A: Demographic data

1. Gender: Male [] Female []
2. Marital Status: Single[] Married[] Divorced[] Widowed[] Others[]
3. Age: 10-20[] 21-30[] 31-40[] 41-50[] 51 and above[]
4. Level of Education: Primary[] Secondary[] Tertiary[] None[]
5. How many children do you have? _____
6. What is your religion?
   (a) Christianity (b) Islam (c) Traditional (d) others {please specify} _____
7. (a) Are you employed Yes [] No [] (b) If yes to 5 (A) what is your job title/description? _____
   (c) How much do you earn monthly? _____

1. (a) Are you employed Yes { } No { } (b) If yes what is your job _____

Section B: Patients responses

Very Sure VS, Sure S, Somewhat Sure SS, Not Sure NS, Don't Know DK

PATIENTS RESPONSES	VS	S	SS	NS	DK
How satisfied are you with the working of the MDT					
Time of arrival to consultation					
Patient input/involvement in patient decision					

Section C

Patient opinion will be based on these set of responses (Strongly Agree SA, Agree A, Indifferent IN, Disagree DA, Strongly Disagree SDA)

PATIENT OPINION	SA	A	IN	DA	SDA
More coordinated patient care					
Positively affect patient care					
Evidence based treatment decision					
Reduce cost of care					
Improve perception of care					
Reduce time between diagnosis and initiation of treatment					
Should be a mandatory part of cancer care					
MDT member should receive more training than available currently					
Improved clinical decision making					
Improved overall quality of treatment					
Improved patient involvement in treatment decision					
Improve survival rate					

Section D: patients opinions to improving quality of service (comments)

1. Which problems do you experience very often in the process of seeing the MDT team?

i. ……

ii. ……

2. What can be done to improve the quality of services?

i. ……

ii. ……