



The Royal College of Pathologists

Pathology: the science behind the cure

The role of the lead pathologist in the multidisciplinary team

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1 Background

The Calman-Hine report on the commissioning of cancer service places multidisciplinary team (MDT) working at the centre of the delivery of cancer services.¹ Although this document focuses on cancer pathology services, similar principles may be applicable to other facets of modern medicine, including non-cancer pathology.

The document applies particularly to histopathologists and cytopathologists, but it may also be relevant to haematologists in haematological oncology MDTs.

The Calman-Hine report does not give specific guidance on the roles of pathologists in MDTs, but components of their roles may be extrapolated from those defined for the MDT lead clinician, namely:

- ensuring supervision of the facilities for cancer care
- ensuring there is adequate non-surgical support
- supervising arrangements for audit and for continuing medical education
- meeting regularly with colleagues from other Cancer Units and Cancer Centres and general practice to guarantee uniform standards
- developing protocols between primary care, Cancer Units and Cancer Centres to ensure an effective network of high standard care.

The Cancer Peer Review (CPR) Standards Manual requires that each cancer MDT has a named 'lead pathologist' as one of the core members,² but gives little further guidance about what this role entails. The appointment of a lead pathologist for each MDT is now common practice, suggesting that the role adds genuine value to the provision of cancer services and is likely to be a permanent feature of cancer MDT working.

This document seeks to define the expected roles of the lead MDT pathologist. These roles may differ in detail between local and specialist MDTs according to site-specific national guidance and local circumstances, but the principles outlined here should be generally applicable.

2 Essential features of the role

2.1 Cancer Peer Review Standards

The Cancer Peer Review (CPR) Standards define the duties of an MDT as follows:

- to ensure that designated specialists work effectively together in teams, such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions.
- to ensure that care is given according to recognised guidelines (including guidelines for onward referrals), with appropriate information being collected to inform clinical decision making and to support clinical governance/audit.
- to ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

Relatively few of the CPR standards specifically relate to pathology, so the details of the role outlined below represent the application of these general principles to the roles of the pathologist within the MDT.

CPR standards require that each MDT must have at least one pathologist as a core member and this pathologist or their deputy must attend at least 50% of all MDT meetings in person or by videolink. The number of pathologists for each MDT who are core or extended members varies and is not overtly limited. In practice, the 50% standard, as strictly defined, is not particularly helpful in defining the role of the lead pathologist, as most MDTs have a level of pathology cover approaching 100%.

CPR requires that each MDT should agree standards for pathology reporting, without specifying how this should be achieved. The lead pathologist is clearly best placed to agree these standards with their clinical colleagues. The setting of pathology standards, beyond the generic requirements of reporting according to The Royal College of Pathologists' cancer datasets and having at least conditional laboratory accreditation (usually through Clinical Pathology Accreditation (UK) Ltd), is described by CPR standards as being the responsibility of Network Site-Specific Groups (NSSGs) and cross-cutting Pathology Cancer Network Groups. It is essential that the lead pathologist for the MDT communicates effectively with both the relevant NSSG and the relevant Cancer Network Pathology Group.

CPR standards require that all core members of each MDT should attend the MDT's annual business meeting. This should be part of the role of the lead pathologist, while not excluding other pathologists who are core members from also attending these meetings.

2.2 Appointment, experience and competencies

As defined in the Cancer Peer Review Standards Manual, the lead clinician for an MDT is responsible for ensuring that there is a designated lead pathologist. The lead clinician would be expected to take advice from the Chair of the Pathology Cancer Network Group in the case of network MDTs and the relevant Clinical Director or Head of Department for local MDTs. Although no specific tenure is defined for the role of lead MDT pathologist and there is no obvious need to limit tenure provided that the roles are fulfilled, it is expected that the role of lead MDT pathologist would be considered during the annual job plan review and would be more formally reviewed by the lead MDT clinician at least every five years.

The lead pathologist for any MDT should regularly report specimens from patients under the care of that MDT. Where the work of an MDT involves more than one specialist area e.g. haematopathology and histopathology or histopathology and cytopathology, the lead pathologist should determine the need for MDT attendance by another specialist pathologist. Defining minimum levels of activity is fraught with difficulty and probably not worthwhile. Just as defining competency in terms of workload would be difficult, defining competency in terms of clinical accuracy is also elusive. Competency is therefore probably best defined in terms of training and quality assurance. For some cancers, there are established national standards set either by the National Institute for Health and Clinical Excellence (NICE) or by other relevant professional bodies. For example, a pathologist who is a core member of a colorectal MDT would be expected to be PELICAN-trained. The NICE 'Improving Outcomes Guidance' (IOG) documents for sarcoma and for skin give competency definitions in terms of participation in appropriate histopathology specialist external quality assessment (EQA) schemes.^{3,4} Where such explicit guidance does not exist, it is appropriate that an MDT lead pathologist should participate in an EQA scheme relevant to that MDT, where one exists. For some MDTs, participation in a general histopathology EQA scheme could be regarded as sufficient and this is the standard recommended for local skin MDTs in the NICE skin cancer IOG. Aspects of the recognition of specialist pathology expertise and quality assurance in histopathology are discussed in more detail in other College documents.^{5,6}

In some circumstances, the lead pathologist is likely to develop an external referral practice for difficult cases in a Cancer Network or nationally. This work should be appropriately funded.^{7,8}

The more generic abilities that would be required by this role are essentially identical to the generic abilities required to be a consultant pathologist and include effective team working and communication skills. The CPR measures indicate that: "The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability". It is reasonable to apply the same principle to the role of lead pathologist, and the Clinical Director for Pathology (or deputy) should regularly review who should most appropriately fulfil the role of lead pathologist in each MDT. The MDT lead clinician should be consulted about any changes in who fulfils the role.

3 Extended features of the role

3.1 Defining and maintaining clinical quality standards

An accredited laboratory will have standard operating procedures (SOPs) covering the dissection and reporting of cancer specimens. These will generally be based on the College's cancer datasets and guidelines from other relevant professional bodies. The responsibility for updating such SOPs will vary from department to department, but is best held by individuals who are in close touch with the literature and national or international developments in any given area of practice. For the work of a cancer MDT, the lead pathologist should fit this description (see also below) and therefore be the individual best equipped to keep reporting protocols up to date.

Where pathology reporting standards are agreed across a Cancer Network, usually through the relevant NSSG, the lead pathologist should take responsibility for implementing these standards. In order to facilitate this, the lead pathologist should either attend NSSG meetings or have direct communication with the pathologist(s) who does attend the meetings.

A major part of the work of pathologists working within MDTs is case review. Case review practice is very variable and adapted to local circumstances, taking into consideration the risk of misdiagnosis in a specific context and the available manpower.⁶ For some MDTs, a large proportion of the caseload will have been reported by the lead pathologist, so this is largely self-review. In other situations, many of the cases will have been double-reported prior to the meeting; local guidelines (incorporating any relevant national guidance) should determine the extent to which further review is necessary. Some IOGs, for example those on skin cancer and sarcoma, have specific guidelines about case review.^{3,4} If, as is usual, case review is a normal part of the working of the MDT, the lead pathologist should have at least one nominated deputy to provide cover during periods of leave. Case review should only be the sole responsibility of the lead pathologist in exceptional circumstances. The lead pathologist may have specific roles in resolving differences in diagnostic opinion that arise within the team of pathologists serving the MDT and as the primary link with external experts to whom difficult cases can be referred.

The lead pathologist, or their deputy, should also ensure that statements about pathology are correctly recorded in the formal minutes of the MDT, that there is appropriate feedback to other pathologists on clinico-pathological correlations and discrepancies, and that formal supplementary reports are issued if relevant to patient management.

The monitoring of quality and outcome data, although recommended as an MDT function in the Calman-Hine report, is still in development. The provision of pathology data for local audit or national reporting should be overseen by the lead pathologist, although information technology systems may allow this work to be carried out without the lead pathologist's active participation.

3.2 Lead in continuing professional development

Although all pathologists are obliged to demonstrate continuing professional development (CPD) in all areas in which they work, in practice it is usual to focus CPD time and effort on areas of special interest. It is appropriate that MDT leads should do this in the specialty that their MDT serves. This puts the lead pathologist in an ideal position to 'horizon scan' and to inform colleagues working in the same specialty of new developments.

3.3 Developing the service

Cancer service developments usually affect pathology. Examples include changes in the volume or complexity of the workload or the introduction of new clinical standards or practices, in particular the implementation of NICE Improving Outcomes Guidance. For any such development to occur smoothly, input from the pathology service is required in the planning process. Operational or budgetary changes that may be necessary generally require input from laboratory managers (clinical or scientific); the lead pathologist is the ideal individual to liaise with the MDT lead and laboratory management in order to bring about any service changes that may be necessary. In the case of Network-wide developments, the lead pathologist should also liaise with relevant colleagues in other pathology departments, Network managerial staff, service users and commissioners.

3.4 Consulting with service users

An essential element of an effective, high-quality diagnostic service is successful interaction with the users of the service, to ensure that the pathology service understands the requirements of its users and the users understand the requirements (and sometimes limitations) of the pathology service. The regular interface between the lead pathologist and other MDT members greatly facilitates this, although specific problems with service

provision may require the input of laboratory and clinical managerial staff. The lead pathologist should facilitate this when necessary.

3.5 Taking the lead in training

A pathologist with specialist experience in any cancer subspecialty⁵ is probably the best qualified individual to lead the training of pathologists, other medical trainees and allied health professionals in that area. Local circumstances will determine the extent to which other colleagues are involved in training.

3.6 Taking the lead in research

Most cancer MDTs will not have their own in-house research portfolio, but will enter patients into clinical trials. Some of these trials will require central histopathology review or request tissue for translational research associated with the trial. Active pathology input into these processes should be coordinated by the MDT lead pathologist.

3.7. Ensuring a reasonable balance of work with colleagues

Taking the lead in the above areas does not necessarily imply doing all the work. Some MDTs may be supported by a number of pathologists who could reasonably share this work, particularly at times of active development such as IOG implementation or if a particular MDT is very active in clinical trials. However, under such circumstances, there would be a need for coordination of these activities and liaison with the MDT lead clinician, roles that should remain with the MDT lead pathologist.

4 Resources required to facilitate effective pathological input to MDT meetings

The lead pathologist should ensure that the need for adequate support for the MDT process⁹ in terms of staffing and facilities is brought to the attention of local service managers.

4.1 Staffing

Time for the preparation of cases (including slide review where necessary) and attendance at the MDT meetings should be incorporated as an element of direct patient care in consultants' job plans. Attendance at business meetings and meetings of Cancer Network Groups should be included in supporting professional activities.

Where the lead pathologist has developed a referral practice for difficult cases from other hospitals, the time commitment and laboratory resourcing implications should be recognised.^{7,8}

Trainee pathologists should have attendance and presentation of cases at MDT meetings built into their training programmes.

Administrative and clerical staffing levels should allow for the (often substantial) time required to retrieve and collate reports and slides in preparation for MDTs. Where cases have to be obtained from (or sent to) other hospitals, the time and resources required should be recognised.

4.2 Facilities

The facilities required for the effective participation of pathologists in MDT meetings will vary according to the requirements of each MDT. An important function of the MDT meeting is the education of undergraduate students and other healthcare professionals on the value of histopathology and cytopathology in the diagnostic process, both in making the diagnosis of cancer and in recognising key features of importance for further management and prognosis. The opportunity to project images at the MDT meeting is valuable, but not essential, in meeting this objective. If digitised images are used, then appropriate image capture, storage and presentation facilities are required. If images are projected from glass

slides, then a good quality microscope and camera need to be provided. The ambience of the room should support the viewing of these images.

According to their interests and experience, the pathologist may also be able to advise on the recording of key clinical and pathological data derived from the MDT process.

5 References

1. Calman C, Hine D. *A Policy Framework for Commissioning Cancer Services. A Report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales.* Department of Health EL(95)51, 1995.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4071083
2. Department of Health. *Manual for Cancer Services*, 2004.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090081
3. National Institute of Clinical Excellence. *Improving Outcomes for People with Sarcoma – The Manual*, 2006. www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7194
4. National Institute of Clinical Excellence. *Improving Outcomes for People with Skin Tumours, Including Melanoma – The Manual*, 2006.
www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7184
5. The Royal College of Pathologists. *The Recognition and Roles of Specialist Cellular Pathologists*, 2006. www.rcpath.org/resources/pdf/G004-SpecialistCellularPathologists-Jun06.pdf
6. The Royal College of Pathologists. *Quality assurance in histopathology*, 2009.
www.rcpath.org/publications [exact URL to follow]
7. The Royal College of Pathologists. *Guidance on histopathology referral practice*, 2007.
www.rcpath.org/resources/pdf/G039HistopathologyreferralpracticeMar07FINAL.pdf
8. The Royal College of Pathologists. *Guidelines on interdepartmental referral and transport of material to other hospitals*, 2009. www.rcpath.org/publications [exact URL to follow]
9. Ashton MA. The multidisciplinary team meeting – how to be an effective participant. *Diagnostic Histopathology* 2008;14:519–523.

Appendix Summary of the potential roles and attributes of a lead MDT pathologist

Essential roles

- Attendance at MDT meetings (to a defined standard).
- Agree pathology standards with MDT lead clinician (in conjunction with the Pathology Cancer Network Group).
- Nominate a deputy who is available to cover for periods of leave.
- Ensure effective communication with both the Network Site-Specific Group and the Pathology Cancer Network Group.

Extended roles (which may or may not be fulfilled by the lead pathologist according to local circumstances)

- Formal review of cases.
- Ensure that cancer-specific Standard Operating Procedures in the laboratory are fit for purpose.
- Attendance at Network Group meetings.
- Working with laboratory managers to ensure that service developments include consideration of the implications for pathology services.
- Lead for continuing professional development in the specialist area.
- Lead for training.
- Lead for research.

Personal attributes

- Appropriate training and experience.
- Participation in appropriate external quality assurance scheme(s).
- Good team-working and communication skills.