
Multidisciplinary Clinics: How to Improve the Follow-up of Patients

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The concept of multidisciplinary specialty clinics evolved in order to provide comprehensive coordinated care for patients with complex diseases. These models have repeatedly been shown to improve clinical outcomes in a variety of conditions (1).

The lifespan of children with esophageal atresia and tracheoesophageal fistula (EA-TEF) has greatly increased since 1941. Over the years, several related morbidities necessitating specific expertise have become obvious. A multidisciplinary care approach appears optimally suited to address the special needs of patients with EA-TEF.

Key considerations include:

1. What are the prerequisites to a successful team?
The mandate of the multidisciplinary team (MDT) should be clear from the onset—common goals are the key—it is more than simply sharing complementary diagnostic and therapeutic skills. To improve efficiency, role assignment and leadership (2) should be clearly identified in order to avoid duplication, overlap, or omissions. A predefined structure, including location of the clinics, should also be part of the initial planning. Dedicated time and resources as well as appropriate workload are essential for success. Finally, the effectiveness of the team should be closely monitored and evaluated on a regular basis (3,4). Obviously, interprofessional collaboration, commitment, motivation, and being a good “team player” are all essential qualities of members in a MDT. Failure of communication with other members of the team could lead to adverse events and clinical incidents (3). Appreciation of the role of others is also critical (3). Having a flexible attitude and a capacity of dealing with conflicts are as well required to be a member of a successful MDT.
But above all, the most important quality is the ability to establish a partnership with the children and their families.
2. Who should be part of a collaborative MDT for patients with EA-TEF? What would be the “perfect” team?
Based on the main expected comorbidities, a core of specialists could be easily defined but other health services should optimally be integrated as well. The key members of the core team should involve a pediatrician, a gastroenterologist, a

surgeon, a pulmonologist, a nutritionist, and a nurse coordinator. Then, in order to respond to the special, specific, and complex needs of the patients with EA-TEF, many other health professionals should join the team, with interaction based on the needs at different times throughout the follow-up of these patients: occupational therapist, ENT specialist, cardiologist, orthopedist, nephrologist, speech therapist, and social worker. The ultimate goal is to respond to the holistic needs of the EA-TEF population despite the actual limited resources we all encounter.

3. The Quebec/Montreal EA-TEF model
Different levels of networking and comanagement currently exist in Quebec, Canada. The RQAO (Réseau Québécois interuniversitaire d'Étude de l'Oesophage) is a provincial network regrouping the 4 university centres of Quebec, both pediatric and adult. The executive members are from both pediatric and adult-care facilities. The mission of the network is to coordinate the care of patients born in Quebec with EA-TEF, to optimize their care and decrease the morbidity related to their condition and finally to increase the pediatric and adult expertise in this specific field. The network will be able to describe the natural history of EA-TEF in Quebec, create a prospective database, and support the parents/patients association of Quebec. All the data collected will be used in a timely fashion to optimize the care at the different stages of life of our patients with EA-TEF to improve their quality of life and prevent complications. Two EA-TEF MDT exist in Montreal: the Ste-Justine Hospital Team and the Montreal Children's Hospital Team. These 2 dedicated MDT provide universal care sharing the same clinical protocols. A transition program incorporating transition clinics has also been integrated into this network model. Transition is essential to bridge pediatric to adult care in order to ensure that comprehensive care is provided throughout the life of all patients with EA-TEF. It is essential to plan this transition with the adult health care physician (1).
4. What are the advantages to a MDT for the EA-TEF population?
Ethics, clinical care, ongoing education of patients and their families, and research are all domains in which benefits appear obvious. Advantages of this collaborative multidisciplinary care team from the patient and parents' perspectives are shown in Table 1 (3,5). For the health care professional, the EA-TEF MDT experience will give him the opportunity to face new challenges, benefit from ongoing education, increase job satisfaction, stimulate his motivation and improve his communication and collaborative skills (3–6). Another advantage is having the support of other team members for the difficult decisions needed to be made as well, support when outcomes are negative (3). MDT is an invaluable resource in the care of the patients with EA-TEF and the key to meet their

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TABLE 1. Advantages of esophageal atresia and tracheoesophageal fistula multidisciplinary team

Patient benefits	Family advantages
Better identification of the patient holistic needs	Continuity of family centered care
Improved quality of care	Access to health care professionals
Coordination of care	Convenience of the clinics
Ongoing education	Ongoing education
Safety	
Increased quality of life	

individual and global needs. Over time, we will gain knowledge on the real impact of this new ongoing multidisciplinary expert care approach on the global outcome and natural history of EA-TEF population. We are confident that these clinics will be a success from the clinical, scientific, and human points of view.

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