The authors reported no conflicts of interest.

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Unfortunately, although it continues to function in an "ad hoc" fashion, our clinic never really got off the ground. The reasons are important to consider here. Although there were some logistical challenges, the main obstacle by far was our failure to get hospital leadership and fellow practitioners to "buy into" our vision. The lack of easily quantifiable benefits made it difficult to make an effective case to hospital leadership in a cost- and resource-conscious environment. And despite our best efforts to include all relevant stakeholders as active partners, we failed at defining the clinic as an additional specialized resource rather than a "competitor" that might encroach upon the professional autonomy of referring physicians or the "authority" of the tumor board. In light of such possible challenges, Madariaga and colleagues' efforts[1] are all the more commendable and all the more important.

We remain more convinced than ever that a dedicated multispecialty clinic is an essential resource within the context of an increasingly complex oncologic reality. It will enable the individualization of care, active participation of patients in decision-making, and optimization of resources. We wholeheartedly encourage other programs to take up this "radical" concept. By keeping this conversation going, we may ultimately succeed in implementing multispecialty collaboration as a new paradigm in thoracic oncology.

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## REPLY: PROVIDING AN HONEST PERSPECTIVE ON CREATING A NEW TREATMENT MODEL

**Reply to the Editor:**

In their correspondence, Rakovich and Bujold highlight their experience with developing a multidisciplinary or "multispecialty" pulmonary nodule clinic. Specifically, they discuss some of the more practical challenges they faced along the way. Among these challenges included obtaining leadership "buy-in" and garnering the trust and support from potential referring partners. Sharing both the successes and the challenges of launching a new treatment paradigm with the greater thoracic community should be encouraged. The comments by Rakovich and Bujold are relevant, helpful, and appreciated.

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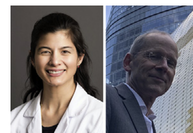

## REPLY FROM AUTHORS: THE MANY BENEFITS OF A MULTIDISCIPLINARY EVALUATION OF LUNG NODULES

**Reply to the Editor:**

There are various reasons to conduct the multidisciplinary evaluation of lung nodules, and no single model, however successful at one time in one institution, may be expected to succeed universally. In their article, Drs Rakovich and Bujold share their vision of a clinic motivated by the increasing age and frailty of patients.[1] We regard their idea as entirely sound. Our clinic originated from the desire to connect radiographic and individual patient risk factors in a conference immediately before those patients whose radiographs were reviewed are provided with an opinion. The concept of a conference was not hurt by the availability of lunch and banter at noon every Friday. What helped in starting our clinic was the willingness of multiple specialists to



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