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Objective of your solution: (Briefly define the primary outcome of your solution to this challenge):

Cancer care isn't managed by one doctor anymore. A single patient might need input from medical oncologists, surgeons, radiation oncologists, radiologists, pathologists, molecular biologists, and palliative care specialists —often across different hospitals and different stages of treatment. That's exactly why multidisciplinary tumor boards exist.

But the process is still broken. Every meaningful MDT discussion demands time, coordination, and multiple specialists in one room. Understanding a single patient's full history can eat up 10-15 minutes before the real discussion even starts. Radiology needs reviewing. Pathology needs revisiting. Molecular reports need correlating. And the reasoning behind earlier decisions? Often poorly documented or completely lost.

Most MDT notes today boil down to one line: "Plan discussed in tumor board. Proceed with chemotherapy." But why was surgery avoided? Why was radiation omitted? What did the radiologist think about mesorectal fascia involvement? What concerns did the surgeon raise? That reasoning vanishes — buried across hundreds of pages of scattered reports, imaging, and fragmented notes.

This matters most in diseases like rectal cancer, where treatment pathways branch constantly. A patient might undergo upfront surgery, total neoadjuvant therapy, organ preservation, watch-and-wait, or a clinical trial. Every decision reshapes the next step. And unless the thinking behind those decisions is preserved, future clinicians are left reconstructing the story from incomplete pieces.

The cost isn't just time. It's continuity, clarity, and collective clinical intelligence.

Describe your solution / proposal: Provide a detailed account of your solution/ proposal to this challenge. You could type your solution/ proposal here. (Disclaimer: Solution/proposal should not exceed more than 300 words.):

1. Milestone: Structured Clinical Decision Platform

Milestone turns every major clinical decision into a documented checkpoint on a longitudinal timeline — sitting as a dedicated tab inside the hospital's existing system. No separate login, no new platform to learn. Structured decision-making becomes as routine as checking a patient's chart.

2. Structured Clinical Milestones

The patient journey unfolds as a chronological timeline from first presentation onward. Each major event — colonoscopy, biopsy, MRI, molecular testing, surgical review, postoperative pathology — has its own template built around the data that actually matters at that moment. Together, these entries form a readable clinical narrative instead of information buried across hundreds of scattered pages.

3. Multidisciplinary Decision Architecture

At major treatment decisions, MDT checkpoints are triggered and the right specialists are brought in for that specific case. Radiologists, pathologists, surgeons, and oncologists can respond via text or audio through a collapsible discussion panel — inside the same milestone, inside the same system. Real multidisciplinary input, without everyone needing to be free at the same time.

4. Preserving the Reasoning

Milestone captures not just the final plan, but what was considered, what was rejected, and where the team was uncertain. When a patient recurs two years later, the next team opens the timeline and understands the thinking — without reconstructing it from scratch.

5. Imaging in Context

Scans, slides, and operative findings attach directly to the milestone they belong to. Specialists can mark specific regions of concern, keeping the image and the interpretation together where they're actually needed.

6. AI-Assisted Documentation

An optional AI layer pre-fills templates from existing notes and records. Clinicians review and confirm —cutting documentation time without removing clinical judgment from the process.
