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Policy statement on multidisciplinary cancer care [☆]



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Abstract Background: Cancer care is undergoing an important paradigm shift from a disease-focused management to a patient-centred approach, in which increasingly more attention is paid to psychosocial aspects, quality of life, patients' rights and empowerment and survivorship. In this context, multidisciplinary teams emerge as a practical necessity for optimal coordination among health professionals and clear communication with patients. The European Partnership for Action Against Cancer (EPAAC), an initiative launched by the European Commission in 2009, addressed the multidisciplinary care from a policy perspective in order to define the core elements that all tumour-based multidisciplinary teams (MDTs) should include. To that effect, a working group conference was held in January 2013 within the EPAAC Work Package 7 (on Healthcare) framework.

Methods: The consensus group consisted of high-level representatives from the following European scientific societies, patient associations and stakeholders: European CanCer Organisation (ECCO), European Society for Radiology & Oncology (ESTRO), European Society for Medical Oncology (ESMO), European Society of Surgical Oncology (ESSO), International Society of Geriatric Oncology (SIOG), European Association for Palliative Care (EAPC), European Oncology Nursing Society (EONS), International Psycho-Oncology Society (IPOS), European Cancer Patient Coalition (ECPC), EuropaColon, Europa Donna - The European Breast Cancer Coalition, Association of European Cancer Leagues (ECL), Organisation of European Cancer Institutes (OEI), EUSOMA - European Society of Breast Cancer Specialists, European Hospital and Healthcare Federation (HOPE) and EPAAC Work Packages 5 (Health promotion and prevention), 7, 8 (Research), 9 (Information systems) and 10 (Cancer plans). A background document with a list of 26 core issues drawn from a systematic review of the literature was used to guide the discussion. Five areas related to MDTs were covered: care objectives, organisation, clinical assessment, patients' rights and empowerment and policy support. Preliminary drafts of the document were widely circulated for consultation and amendments by the working group before final approval.

Results: The working group unanimously formulated a *Policy Statement on Multidisciplinary Cancer Care* to define the core elements that should be implemented by all tumour-based MDTs. This document identifies MDTs as the core component in cancer care organisation and sets down the key elements to guide changes across all European health systems.

Conclusion: MDTs are an essential instrument of effective cancer care policy, and their continued development crucial to providing patients the care they need and deserve. While implementation must remain in local hands, European health systems can still benefit from having a basis for an effective multidisciplinary model of cooperation. This policy statement is intended to serve as a reference for policymakers and healthcare providers who wish to improve the services currently provided to the cancer patients whose lives and well-being depend on their action.

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1. Introduction

Optimal decision-making in the diagnosis, treatment and support of cancer patients is being increasingly associated with multidisciplinary teams (MDTs) [1]. Cancer care involves a growing number of specialists and health professionals as intervention areas expand to encompass psychosocial support, genetics and frailty aspects (among other areas) and consensus decisions are needed at all stages of care. As the care pathway becomes more complex, the potential for miscommunication, poor coordination between providers and fragmentation of services increases. This constitutes a challenge for patients and families as well as for caregivers.

MDTs were identified by the Lisbon roundtable (Portuguese European Union (EU) Presidency, 2007) as the

best approach to organising cancer care in a way that consistently brings together all healthcare professionals involved in cancer diagnosis and treatment [2], and the EU Parliament and Council has also expressed support for these teams as a way to cope with coordination and communication issues associated with the implementation of the European reference networks for rare diseases [3]. Likewise, several European cancer control plans stress the importance of multidisciplinary care, setting specific guidance for its implementation [4,5]. However, this prioritisation coexists with significant differences in performance, implementation and organisation of cancer care and access across countries [6,7] as well as in policy measures taken to promote this approach. While implementation must remain in local hands, European health systems can still benefit from having a basis for an effective multidisciplinary model of cooperation.

To that effect, the European Partnership for Action Against Cancer (EPAAC), launched by the European Commission in 2009, identified multidisciplinary care as a key element in cancer care [8,9]. Work Package 7 (on Healthcare) initiated a process based on research and discussion among European stakeholders, which has led to the present statement. Firstly, a systematic review of the evidence was carried out, which showed how MDTs resulted in better clinical and process outcomes for cancer patients in terms of survival and reduction of waiting time from diagnosis to treatment [10]. However, the benefits of a team approach extend to multiple dimensions of care delivery, with many papers reporting improvements in patients' quality of life and access to clinical trials as well as in the coordination of services. The MDT organisational approach is evolving towards an expanded role that embraces the whole process of patient care, from diagnosis to follow-up [11].

In addressing the policy approach to multidisciplinary care, a working group comprising key European stakeholders was organised. A background document with a list of 26 core issues drawn from the review was used to guide the discussion. Five areas related to MDTs were covered: care objectives, organisation, clinical information and assessment, patients' rights and empowerment and policy support. The discussion took place during the WP7 meeting in Barcelona on 31st January 2013 and involved high-level representatives from European scientific societies, European patient associations and European stakeholders, along with the EPAAC Work Packages on Health Promotion and Prevention, Research, Information Systems and Cancer Plans.

The working group unanimously formulated a policy statement to define the core elements that should be implemented by all tumour-based MDTs. Preliminary drafts of this *Policy Statement on Multidisciplinary Cancer Care* were widely circulated for consultation and amendments by the working group before final approval.

2. Rationale and definition of multidisciplinary teams (MDTs)

The working group stated MDTs' underlying rationale in accordance to the following remarks:

- Given the multiple benefits of MDTs and the imperative to equitably provide all patients with the best possible care, the promotion of MDTs should be considered an ethical priority.
- Because of the consensus mechanisms that MDTs imply, including verification that decisions are consistent with available evidence, fostering MDTs is imperative to ensuring appropriate clinical decisions.

- Multidisciplinary clinical practice guidelines and those covering all aspects of care from a multidisciplinary perspective deserve special attention.
- It is beyond any doubt that MDTs require time and effort; hence, clinical leadership and firm commitment by health care providers and administrators are prerequisites for changes in management and sustainability of team structures.
- The dynamic nature of cancer care brings organisations to increasingly rely on networks for knowledge and expertise. Such a multilevel outlook, which is not only longitudinal in nature, underlines the need for structured inter-professional collaboration.
- Consistent MDT work is crucial for dealing with future challenges like survivorship and support for research.

Likewise, in addressing the role of MDTs, a new definition was put forward:

Multidisciplinary teams (MDTs) are an alliance of all medical and health care professionals related to a specific tumour disease whose approach to cancer care is guided by their willingness to agree on evidence-based clinical decisions and to co-ordinate the delivery of care at all stages of the process, encouraging patients in turn to take an active role in their care.

3. The following statements, drawn up by the working group, reflect the existing expert consensus on multidisciplinary care

3.1. Care objectives

The confirmation of a cancer diagnosis should prompt the initiation of multidisciplinary team (MDT) monitoring, including all the diagnostic and therapeutic specialties involved in the care process. Patients' early access to the MDT should ensure that appropriate treatment is selected based on the preoperative assessment of imaging and pathology results. After staging, MDT consensus and patient consent on an evidence-based treatment plan is required for every cancer patient. This decision-making process should be consistent with evidence-based European clinical practice guidelines, if available. During MDT meeting discussions, guidelines should be tailored to the type of tumour and the specific condition of the patient, including comorbidities and frailty. Treatment decisions, which impact patients' quality of life to varying degrees, should not be made without information on patient preferences for treatment and/or care.

In addressing other care objectives, patients should always have ready access to counselling for psychosocial support; patient distress is particularly important and should be screened for from diagnosis onwards. Access to counselling should also be provided for other supportive care needs, with special emphasis in regard to the patient's nutritional state.

After finalisation of active treatment, the follow-up period should not begin without the team's elaborating a joint survivorship care plan with the patient. In accordance to tumour-site requirements, such a plan should specify two areas of care: (i) routine surveillance of a possible relapse and (ii) post-treatment needs, including rehabilitation, well-being actions and reintegration into the workforce. If needed, adequate integration between the tumour-based MDT and palliative care team should also be assured so as to reinforce continuity in the care pathway.

Primary care physicians should be offered a seat on the tumour boards dedicated to their patients, and detailed information should be provided to them regarding the clinical decisions made. General Practitioners (GPs) should play a key role in framing cancer within long-term care, providing advice on comorbidities and a holistic health assessment of the patient's care needs. Moreover, MDTs should be familiar with all clinical trials available in the healthcare centre, offering access for their patients.

3.2. MDT organisation

Multidisciplinary teams should monitor all new and recurrent cancer patients, and every case should be presented at a tumour board, either for discussion or verification that the treatment recommendation is consistent with the evidence. It is important to formally assign every specialist involved in cancer diagnosis and treatment to the multidisciplinary tumour board, protecting time for their attendance and promoting team involvement.

Accepted MDT care protocols, updated at least biennially to take into account emerging scientific breakthroughs, are also important. The multidisciplinary process offers valuable educational experiences and potential for quality improvement actions, and MDTs should remain responsive and proactive in promoting them. Benchmarking actions should play a key role in improving and auditing teamwork performance.

All MDTs should designate a coordinator or chair to ensure efficient discussions within tumour boards; this individual should be in charge of securing professionals' attendance, preparing patient lists and effectively implementing the decisions made by the team. In agreement with the team, the coordinator should also arrange the involvement of other specialists as needed. The leading

position should be temporary and a clear definition of the nomination process and of a rotations system should be in place.

An expert nurse or qualified staff member should provide case management throughout the care process, acting as a point of contact for both patient/families and team. Some of the most important tasks assigned to this professional profile include providing expert clinical advice to patients, exchanging key patient information and care recommendations with the physicians, attending tumour board meetings and ensuring that diagnostic and treatment times are consistent with the targets set in this regard.

3.3. Clinical information and assessment

All MDTs should develop a prospective database with clinical indicators, considering the use of synoptic reports. Information gathered on key clinical variables and therapeutic strategies should be available for evaluation of the outcomes by the team, which may enable benchmarking among MDTs. Data on the care process, such as time to diagnosis (when feasible to assess), time to first treatment and relapse, should be included among essential indicators, to be analysed periodically in the interest of identifying reasons for delay and rectifying them whenever possible.

The hospital's clinical information system should record the decisions taken and rationale used with regard to every patient, as initially reported in the minutes of the tumour board meetings. If possible, this information should be linked to the population-based cancer registry, if it exists. In this regard, a minimum set of variables (including stage) should be agreed upon.

3.4. Patients' rights and empowerment

Efforts must be made to ensure an MDT care model based on fluid communication with patients and shared decision-making whenever possible and appropriate. To that effect, patients' treatment and care preferences (particularly those affecting quality of life) should be discussed with them before making clinical decisions. Likewise, patients should have access to a second opinion and the opportunity to choose from different treatments and providers.

Patients should be able to identify a responsible physician at every stage of the care process. In addition, there should be a designated case manager or other professional responsible for communicating with patients across the various stages of care in order to ensure adequate communication. In this regard, improvement of the patient experience, with special focus on the specific needs of disadvantaged individuals, should be considered a key element of the quality of care.

All teams should take measures to improve the level of information that patients have, thereby optimising their potential involvement. Firstly, information on MDT organisation should be provided to promote a greater understanding of the specific collaborative approach. Also, a comprehensive report of the full care process should be made available to the patient when a significant change of the clinical situation is observed and change in the therapeutic approach is deemed necessary. Moreover, access to appropriate electronic data records should be facilitated for patients.

In order to encourage self-care and empowerment, written or digital materials and tools should be provided to manage treatment-related toxicities and adverse effects. Finally, information about community resources, including local patient support groups, volunteer programmes, and informative and trustworthy websites, should be offered to patients at all stages of care. Patients and volunteer organisations are welcome at cancer centres. A closer relationship should imply playing an active role in caring for patients' personal and social needs, which requires a certain degree of consent and coordination with MDTs and centre staff.

3.5. Policy support

Moving towards an integrated model of MDT cancer care entails the policy involvement of European and national scientific societies and patient associations. Cancer control plans have a key role in the development of strategies for multidisciplinary progress in cancer care as well, often including specific funding mechanisms to stimulate this organisational approach.

National and regional authorities and professional organisations should also prioritise this issue on their agendas and promote specific guidance, stressing the importance of MDTs as a cornerstone of modern cancer care.

4. Conclusion

The discussion carried out to reach consensus on these elements involved the effective exchange of best practices and criteria for successful implementation among scientific societies, patients and other European stakeholders. In this process, no assumptions were made that the issues surrounding multidisciplinary models of organisation had been resolved or that they were an exclusive concern of healthcare providers. The discussion revealed considerable consensus with regard to some perspectives and meanings, along with divergences on others.

This document identifies MDTs as the core component in cancer care organisation and sets down the key elements to guide changes across all European health systems. Core pillars of an effective MDT include the following:

- Clear care objectives that have the agreement of MDT diagnostic and therapeutic members and patients, covering issues around diagnosis, treatment and survivorship;
- Organisation of the MDT that establishes operative leadership and coordination, designates a point of contact for patients, includes benchmarking exercises that integrate emerging scientific breakthroughs and reserves specific time and resources for physicians and healthcare professionals to participate on tumour boards.
- Information databases that record clinical decisions, outcomes and indicators, facilitating the assessment of progress and the identification of areas to further improve;
- Patient-centred approach, with available and comprehensible information on clinical and psychosocial aspects of the care process, clear communication channels between the care team and the patient and the promotion of participation and choice;
- Policy support from national and regional health authorities, scientific societies and patients' organisations, with special attention to including mechanisms to establish and sustain MDTs through national cancer control plans.

In conclusion, cancer care is undergoing an important paradigm shift from a disease-focused management to a patient-centred approach, in which increasingly more attention is paid to psychosocial aspects, quality of life, patients' rights and empowerment, comorbidities and survivorship. While these new dimensions add complexity to cancer service organisation, they also bring opportunities to improve quality, making cancer care more tailored to individuals and subsequently more effective in addressing patient needs and improving outcomes. Multidisciplinary teams emerge as a practical necessity for optimal coordination among health professionals and clear communication with patients, but the planning, organisation and implementation of such structures are still subject to intense debate among the integrated cancer care community.

We hope that the framework described in this policy statement will serve as a reference and as motivation for policymakers and healthcare providers who

wish to improve the services currently provided to the cancer patients whose lives and well-being depend on their action. MDTs, we believe, are an essential instrument of effective cancer care policy, and their continued development—throughout Europe and beyond—is crucial to providing patients the care they need and deserve.

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Conflict of interest statement

None declared.

References

- [1] Haward R. Organizing a comprehensive framework for cancer control. In: Alexe D-M, Albrecht T, McKee M, Coleman MP, editors. *Responding to the challenge of cancer care in Europe*. Ljubljana: Institute of Public Health of the Republic of Slovenia and European Observatory on Health Systems and Policies (EOHSP); 2008. p. 113–34.
- [2] Gouveia J, Coleman MP, Haward R, et al. Improving cancer control in the European Union: conclusion from the Lisbon roundtable under the Portuguese EU presidency (2007). *Eur J Cancer* 2008;44:1457–62.
- [3] Directive 202011/24/EU of the European Parliament and of the Council on the Application of Patients' Rights in Cross-border Healthcare. 9 March 2011. p. L 88/62.
- [4] Atun R, Martin-Moreno JM, Ogawa T. *Analysis of national cancer control programmes in Europe*. London: Imperial College London Business School; 2009.
- [5] Department of Health. The generic multidisciplinary team (MDT). In: *Manual for cancer services (part one)*. UK: Department of Health; 2004. Topic 2-A.
- [6] Saini KS, Taylor C, Ramirez AJ, et al. Role of the multidisciplinary team in breast cancer management: results from a large international survey involving 39 countries. *Ann Oncol* 2012;23:853–9.
- [7] Ruhstaller T, Roe H, Thürlimann B, Nicoll JJ. The multidisciplinary meeting: an indispensable aid to communication between different specialities. *Eur J Cancer* 2006;42(15):2459–62.
- [8] Jelenc M, Van Hoof E, Albrecht T, et al. Joint action European partnership for action against cancer. *Arch Public Health* 2012;70:24.
- [9] Communication from the Commission on Action Against Cancer: European Partnership. COM; 2009. 291/4.
- [10] Prades J, van Hoof E, Remue E, Borras JM. Multidisciplinary teams in cancer care: a systematic review of the evidence. Deliverable 1, specific objective 1.1; Work Package 7 of the European Partnership for Action Against Cancer (EPAAC). Available from: www.epaac.eu.
- [11] Fennell ML, Das IP, Clauser S, Petrelli N, Salner A. The organization of multidisciplinary care teams: modeling internal and external influences on cancer care quality. *J Natl Cancer Inst Monogr* 2010;40:72–80.