



# Multidisciplinary meetings for cancer care

A GUIDE FOR  
HEALTH SERVICE PROVIDERS



NATIONAL BREAST  
AND OVARIAN  
CANCER CENTRE

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DEPARTMENT OF HEALTH AND AGEING

**Multidisciplinary meetings for cancer care: a guide for health service providers**

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# Foreword

Multidisciplinary care (MDC) has been highlighted in national and international reports as an essential component in the management of patients with cancer. However, there is often confusion about what constitutes MDC, which patients should be discussed, who should be involved in decision making and how decisions should be recorded.

In 2003, the National Breast Cancer Centre (NBCC) completed a three-year National Demonstration Project examining the process, impact, acceptability and cost of implementing sustainable strategies to improve MDC for breast cancer at three multi-facility sites in Australia. The project was supported by an Observational Study examining 'best practice' in established MDC meetings for breast cancer treatment planning, and a follow-up Sustainability Study conducted 19 months after study completion. The outcomes of these projects are reported elsewhere<sup>1,2</sup> and have led to the development of a set of policy recommendations promoting the importance of multidisciplinary cancer care. One recommendation is that a guide for health service managers be developed to assist in the planning and running of MDC meetings for cancer care.

This guide has been developed with input from a multidisciplinary Working Group and draws upon the experiences of those sites that participated in the NBCC Demonstration Project and Observational Study, as well as other national and international evidence and experience. The guide focuses on MDC meetings and assumes that a decision has been taken by the user(s) to implement meetings. The guide is not intended to be prescriptive but instead will provide health service providers and multidisciplinary team members with ideas and tools to improve MDC at a local level. It will be useful both for groups wishing to implement new MDC meetings and for teams that want to improve the efficiency and effectiveness of existing processes.

The guide is designed to assist in the implementation of MDC for all cancers. Recommendations from the NBCC's Demonstration Project in breast cancer, quotations from the NBCC's Sustainability of Multidisciplinary Cancer Care Study, and a range of case studies are used as examples only based on the experience of the guide developers.

The guide is designed to be a 'living document'. Comments on ways to improve the guide, including case studies and templates/proformas, are welcomed and should be submitted via email to: [director@nbcc.org.au](mailto:director@nbcc.org.au) or fax: (02) 9036 3077. Updates to the guide will be available on the NBCC's website: [www.nbcc.org.au/mdc](http://www.nbcc.org.au/mdc)



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# WHY IMPLEMENT MULTIDISCIPLINARY CARE?

A summary for health service administrators

*“ we built a lot of trust  
across the private–public interface  
– before it was a barrier,  
and now it is an interface... ”*

CANCER SPECIALIST INVOLVED  
IN THE NBCC DEMONSTRATION PROJECT

## Cancer in Australia

Cancer is a national health priority area. In Australia, one in three men and one in four women will be affected by cancer by the time they are 75 years of age.<sup>3</sup> In 2000–2001, annual health expenditure due to cancer in Australia was \$2.6 billion,<sup>3</sup> representing around 5.5% of the annual health care budget for Australia.

Australia has a complex health system, with patients treated in both the public and private sectors and in urban, regional, rural and remote areas. Cancer care is delivered in a variety of settings and involves a range of services including screening, diagnosis, treatment (surgery, systemic therapies and radiotherapy), rehabilitation, supportive care and palliative and end-of-life care. Each service involved cannot be viewed in isolation. In 2004 the National Service Improvement Framework for Cancer,<sup>4</sup> a joint initiative of the Australian Government and States and Territories, identified that *“a more coordinated approach to cancer is required which enables networked integrated services to be provided within a patient-centred and multidisciplinary framework.”*

## Multidisciplinary care benefits for service provision

“there’s been a lot of change in the referral patterns, very much more streamlined than it was (as a result of the MDC meetings)...”

Multidisciplinary care (MDC) is an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient.

There is increasing evidence that MDC improves patient outcomes. The benefits of adopting a multidisciplinary approach include:

- improved patient care through the development of an agreed treatment plan<sup>5</sup>
- provision of best practice through the adoption of evidence-based guidelines<sup>5-8</sup>
- improved patient satisfaction with treatment<sup>9,10</sup>
- improved mental well-being of health professionals<sup>9</sup>
- streamlining treatment pathways<sup>1,10</sup>
- reduction in duplication of services<sup>11</sup>
- improved access to possible clinical trials of new therapies<sup>8</sup>
- increasing the timeliness of appropriate consultation and surgery and a shorter timeframe from diagnosis to treatment.<sup>10,12,13</sup>

See page 6–7 for more information about the evidence of benefits of MDC.



## Multidisciplinary care and cancer services

“*the benefits have spread into all our activities ....  
it's made a complete difference to the whole  
specialist network in the hospital...*”

As the benefits of MDC continue to emerge, the importance of its implementation is being highlighted and incorporated into cancer guidelines, reports, frameworks and plans at National, State and Territory levels.<sup>4,6,7,14-17</sup> In 2005 the National Breast Cancer Centre (NBCC), on behalf of the Australian Cancer Network, developed a recommended framework for standards for cancer services. *The National Cancer Services Standards Framework*<sup>18</sup> includes nine recommended topic areas in which standards should be developed. One of the nine topic areas for which it is recommended that protocols and processes should be adopted is MDC. It is recommended that the standards framework form the basis of any ensuing national accreditation system for cancer services.

## Multidisciplinary care in Australia

While a number of health services in Australia participate in MDC to some extent, published sources reveal little, if any, information about its components, barriers and enablers, nor any established or recommended models or strategies for the Australian context.

The *National Demonstration Project of Multidisciplinary Care*,<sup>1</sup> conducted by the NBCC in 2000–2002, identified barriers and enablers of MDC, and sustainable strategies to implement or improve MDC, with the benefits of such strategies ultimately becoming the driver for their ongoing success. The strategies led to flow-on effects to other cancers and chronic diseases managed by the services and requiring multidisciplinary input.

As a result of the NBCC Demonstration Project, the NBCC made a number of recommendations to promote MDC as an integral part of national policy for cancer care (see Appendix A).

### Key enablers to the uptake and ongoing sustainability of MDC strategies from the NBCC Demonstration Project<sup>1</sup> included:

- identification of local champions with leadership qualities to drive change and gain peer support
- provision of dedicated funding to support new strategies
- administrative personnel to assist in the set-up and coordination of meetings
- provision of adequate infrastructure, such as venues and telecommunications equipment.

**Commitment and buy-in from team members was also crucial to the ongoing success of the strategies.**

**The importance of gaining early support from senior hospital administrators has been identified as an important factor in ensuring sustainability.**

## A guide for health service providers

This guide is designed to provide practical advice for health professionals and health service administrators about how to implement MDC at the local level. While we hope that it will provide useful information, it will not by itself be sufficient to ensure the uptake of MDC. In order for MDC to become incorporated into standard practice for cancer care in Australia, improvements in patient management must be adequately and explicitly resourced by health service providers.



## WHAT IS MULTIDISCIPLINARY CARE?

*“we’ve seen a transition from the presentation of ‘a case of breast cancer’ with a lot of technical detail, to the presentation of ‘a woman with breast cancer’, with background details about who this woman is, what’s going on in her life, what her desires might be, and how that might impact on decision-making ...”*

Multidisciplinary care (MDC) is an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient. That is, MDC is about all relevant health professionals discussing options and making joint decisions about treatment and supportive care plans, taking into account the personal preferences of the patient.

The need to develop strategies to encourage participation by clinicians and health service providers in MDC has been highlighted in several national cancer policy documents<sup>4,15,17</sup> and is a critical intervention point in the National Service Improvement Framework (NSIF) for cancer.<sup>4</sup> The NSIF is a key direction for the National Health Priority Action Council for 2003–2005 and the critical intervention points identified indicate areas where Australia might most usefully invest to reduce death and suffering from cancer.

*“people who had unusual patterns of care have normalised them ... [now] treatment is much more aligned to guidelines ...”*

### Why is multidisciplinary care important?

MDC is a key mechanism for ensuring that all relevant disciplines contribute to decisions about the care of patients with cancer. Evidence indicates that a team approach to cancer care can reduce mortality and improve quality of life for the patient.<sup>5,19,20</sup> There is also evidence that decisions made by a multidisciplinary team are more likely to be in accord with evidence-based guidelines than those made by individual clinicians.<sup>5</sup> Furthermore, patient satisfaction with treatment and the mental well-being of clinicians in a multidisciplinary team has been shown to be improved by a multidisciplinary approach to care.<sup>9,10</sup>

## Benefits of multidisciplinary care

*“the benefits [of the meetings] have just been absolutely incalculable to us ... mutual learning experiences, mutual communication pathways, they have spread into all our activities throughout the hospital ...”*

Benefits and incentives for clinicians to participate in MDC, highlighted through the NBCC Demonstration Project and elsewhere, include:

- patient care is more likely to be evidence-based, with implications both for clinical outcomes and cost-effectiveness<sup>1,5</sup>
- all treatment options can be considered, and treatment plans tailored for individual patients<sup>1</sup>
- referral pathways are more likely to be streamlined<sup>1,10</sup>
- clinicians have enhanced educational opportunities<sup>1</sup>
- meetings provide opportunities for clinicians to interact with colleagues<sup>1</sup>
- clinicians who work as part of a team have a significantly lower incidence of minor psychiatric morbidity than in the general health-care workforce.<sup>9</sup>

Positive outcomes of MDC for patients, identified through the NBCC Demonstration Project and elsewhere, include:

- increased survival for patients managed by a multidisciplinary team<sup>19</sup>
- increased perception by the patient that care is being managed by a team<sup>1</sup>
- greater likelihood of receiving care in accord with clinical practice guidelines, including psychosocial support<sup>5</sup>
- increased access to information, particularly about psychosocial and practical support<sup>1</sup>
- increased patient satisfaction with care.<sup>10</sup>

## EVIDENCE OF THE BENEFITS

- A study in the USA<sup>5</sup> compared breast cancer treatment recommendations made by a multidisciplinary panel with earlier recommendations made by doctors who were not part of the multidisciplinary clinic. For 43% of women, the treatment recommended by the multidisciplinary panel differed from that recommended by the other physicians. Where differences occurred, the recommendations of the multidisciplinary panel were more likely to be in accord with evidence-based guidelines.
- A Scottish study<sup>20</sup> compared the survival of women who had been treated by specialist and non-specialist teams. The study reported that the five-year survival rate was 9% higher and the 10-year survival 8% higher for patients cared for by specialist surgeons. The authors noted that, *“specialist interest was characterised by their setting up dedicated breast clinics, having a defined association with pathologists and oncologists and organising and facilitating clinical trials as well as maintaining a separate record system of all breast cancer cases in their unit’s care.”*
- A USA study<sup>10</sup> found the time between diagnosis and initiation of treatment was significantly decreased in the MDC setting. Patient satisfaction also increased significantly as a result of involving the patient and their family/friends when making treatment decisions.

## Principles of Multidisciplinary Care

Australia presents a challenge for the implementation of MDC, given the mix of private and public service provision, and significant regional variations in service delivery and access. Models of care developed overseas are not directly applicable to the Australian context.

The *Principles of Multidisciplinary Care*,<sup>21</sup> developed by the NBCC, provides a flexible definition of MDC, allowing for variation in implementation according to cancer type and the location of service provision. The *Principles* are designed to be relevant for all cancers, not just breast cancer, and for a variety of health-care settings.

**THE PRINCIPLES OF MULTIDISCIPLINARY CARE<sup>21</sup>  
EMPHASISE THE NEED FOR:**

- a **team approach**, involving core disciplines integral to the provision of good care, including general practice, with input from other specialties as required
- **communication** among team members regarding treatment planning
- access to the **full therapeutic range** for all patients, regardless of geographical remoteness or size of institution
- provision of care in accordance with **nationally agreed standards**
- **involvement of patients** in decisions about their care.

Appendix B provides a full overview of the *Principles*, including suggested criteria by which they would be satisfied for evaluation purposes.

## Checklist for *Principles of Multidisciplinary Care*<sup>1,21</sup>

Use the checklist below to assess whether the systems in place for MDC for patients with cancer at your institution are in line with the *Principles of Multidisciplinary Care*.

PRINCIPLE OF CARE	YES/NO
<b>TEAM</b>	
Is there an established multidisciplinary team comprising all core disciplines integral to good patient care?	
Is the patient's general practitioner included as a team member and kept informed of team activity?	
Have referral links been established with non-core team specialist services (eg genetic counselling, physiotherapy, psychology)?	
<b>COMMUNICATION</b>	
Are regular multidisciplinary team meetings held to discuss treatment planning?	
Do all core disciplines attend and provide input into the multidisciplinary team meetings – diagnostic, treatment and supportive care?	
Is there a protocol to decide which patients should be discussed at multidisciplinary team meetings?	
<b>FULL THERAPEUTIC RANGE</b>	
Do all patients have access to relevant services?	
<b>STANDARDS OF CARE</b>	
Are protocols and clinical pathways available? If yes, are processes in place to ensure that local practice is in line with guidelines?	
Are patient preferences discussed in multidisciplinary team meetings?	
Are all relevant test results, reports and films available during multidisciplinary meetings?	
Is the number of cases seen at the site small? If yes, are collaborative links with larger units/centres in place?	
Are professional development activities held regularly?	
<b>INVOLVEMENT OF THE PATIENT</b>	
Are patients routinely offered information about all aspects of their treatment choices?	
Are patients routinely given information about, and access to, supportive care services?	
Are patients informed that their care is discussed in a multidisciplinary forum?	
Is patient consent obtained according to local protocol?	
Are patients informed who the 'team leader' is?	

## Models of multidisciplinary care

This guide provides a template for the implementation of MDC for all cancers, primarily using breast cancer as an example. There are a number of models of MDC in Australia. These include:

- a 'tumour board' model, in which the patient's case is discussed by the team, a recommendation for treatment is made and the treating clinician informs the patient of the recommendation, with referrals made as appropriate
- a variation of this model, in which the patient attends a clinic after the discussion and meets the members of the team who will be involved in ongoing care.

There is no one 'correct' model or formula. The aim of the *Principles of Multidisciplinary Care* is to allow flexibility in process while ensuring that key underlying principles are in place.

*“I think the (MDC Demonstration) Project gave us the legitimacy to always be consulting the other disciplines ...it's now an established standard of care ...it changed the culture ...”*

## The multidisciplinary team

The multidisciplinary team should comprise the core disciplines integral to the provision of good care. Team membership will vary according to cancer type but should reflect both clinical and psychosocial aspects of care. Inclusion of a supportive care provider in the core team is essential – this may be a nurse specialist, oncology nurse, social worker or psychologist. The patient's general practitioner is also a member of the team. The general practitioner may play a number of roles in all stages of the disease process, including diagnosis, referral, treatment, coordination and continuity of care as well as provision of information and support to the patient and his/her family. While it may not be possible for general practitioners to attend multidisciplinary team meetings on a regular basis, it is essential that the general practitioner is kept informed in a timely manner about treatment decisions (see page 24).

Additional expertise or specialist services may be required for some patients. Such services may be some distance away from the main treatment centre or have limited availability (eg relative scarcity of specialist psychiatry or genetic services in some regions). However, geographical remoteness and/or small size of the institution delivering care should not be impediments to the delivery of MDC nor to access to services. Systems should be established to support collaborative working links between team members. It is important that referral links with remote services are established and can be drawn upon as required.



### EXAMPLE OF MULTIDISCIPLINARY TEAM MEMBERSHIP FOR TREATMENT PLANNING: BREAST CANCER<sup>1</sup>

#### Core team members

Surgery  
Medical oncology  
Radiation oncology  
Pathology  
Radiology  
Supportive care  
–*oncology nurse/breast care nurse*  
General practice

#### Non-core team members

Genetic/hereditary counselling  
Physiotherapy  
Psychiatry/psychology  
Nuclear medicine  
Plastic surgery  
Palliative care  
Social work

### EXAMPLE OF MULTIDISCIPLINARY TEAM MEMBERSHIP FOR TREATMENT PLANNING: LUNG CANCER

#### Core team members

Respiratory medicine  
Cardiothoracic surgery  
Medical oncology  
Radiation oncology  
Pathology  
Radiology  
Nurse specialist  
Palliative care

#### Non-core team members

Nuclear medicine  
Social work  
Physiotherapy  
Psychiatry/psychology  
Dietetics  
Occupational Therapy

## CASE STUDY: SETTING UP A TEAM

**THE CHALLENGE:** To establish a multidisciplinary treatment planning meeting for the management of breast cancer in a rural/regional area consisting of one large regional centre with one public and two private hospitals, and a number of smaller rural hospitals covered by four main health services.

**ISSUES RAISED:** A number of barriers and obstacles were faced in setting up the team.

**TIME:** The majority of stakeholders voiced concerns about the time that would be required to attend multidisciplinary meetings and the impact this may have on their clinical practice.

**PRIVACY ISSUES:** Many clinicians were concerned about breaches of privacy with patients being discussed in a team environment.

**PUBLIC/PRIVATE PATIENTS:** In a regional/rural setting, most clinicians work in both the public and private sector. Those with a significant private practice were unwilling to present patients at a meeting held in the public health service.

**LACK OF A COMPLETE TEAM IN THE RURAL AREAS:** Rural clinicians identified the lack of oncologists at multidisciplinary meetings in rural areas and the need to have linkage to the larger regional centre.

**THE SOLUTION:** Establishment of MDC across a large regional and rural area required face-to-face consultation with stakeholders in all sectors, discipline groups and health services. Meetings provided information about MDC and, in particular, the advantages for clinicians and patients and the opportunity to discuss issues and look at the way forward. Within health services, the executive team was invited to planning meetings to seek support for the necessary changes.

**THE RESULT:** As a result of the consultation, many clinicians recognised that the development of MDC represented best practice and subsequently met to attempt to overcome the obstacles. Within six months the regional multidisciplinary team was meeting on a weekly basis and prospective treatment planning was established. The clinicians were initially concerned about the time commitment, but quickly recognised that most discussion took place at meetings, thus reducing the need for telephone calls and communication at other times.

To overcome clinician concern about discussing private patients in the public sector, an agreement was reached to meet at one of the private hospitals and to date the team has continued with this practice. Team members have realised that benefit could be gained by videoconferencing to the rural areas and initial discussions have taken place to plan this strategy.

**THE SITUATION NOW:** Weekly meetings are held to prospectively plan treatment and care for women diagnosed with early, advanced and recurrent breast disease. On average, 22 health care professionals attend the meetings, but there are often 28–30 attendees. The core team consists of one or more pathologists, radiologists, surgeons, medical oncologists and radiation oncologists, along with general practitioners, breast care nurses and social workers. One rural area has commenced videoconference linkage to the regional hospital, which is the main cancer referral centre, to ensure oncology input to treatment planning.

## CASE STUDY: INVOLVING GENERAL PRACTITIONERS

**THE CHALLENGE:** General practitioners are pivotal in providing information and coordination of care to the patient and his/her family and are therefore important members of the MDC team.

**THE SOLUTION:** To ensure that general practitioners participated in the planning phase, with a view to their participation in multidisciplinary meetings, focus groups were held at clinics in the regional area and through the Division of General Practice in two rural health services. Attendance at these meetings was impressive and though the attendees identified many obstacles to attendance at multidisciplinary meetings, they were enthusiastic about participating.

**THE SITUATION NOW:** General practitioners routinely attend the multidisciplinary meeting in the regional centre and on many occasions in the rural centres. The relevant Division of General Practice is notified of the name of the general practitioners who are to have patients discussed that week and through this mechanism, general practitioners are invited to the meeting. The liaison general practitioner from the Division of General Practice attends the majority of meetings and is able to convey information about treatment planning to those general practitioners unable to attend the meeting.

## Multidisciplinary team list

Use the table below to list the names and contact details of team members. Ensure that all team members have a copy of this list. Identify which team member will undertake the role of care coordinator.

DISCIPLINE	NAME AND CONTACT DETAILS
Surgery	
Medical oncology	
Radiation oncology	
Pathology	
Radiology	
Supportive care	
General practice	
Physiotherapy	
Psychology	
Plastic surgery	
Nursing	
Social work	
Palliative care	
Genetic counselling	
Nuclear medicine	
Other	

## Cancer care coordinators

*“The MDC meeting certainly became much more efficient once the breast care nurse came in ...”*

*“the feedback from the women (about the breast care nurse) is very, very positive ...”*

CLINICIAN

The cancer care coordinator is a rapidly emerging role within multidisciplinary teams.<sup>22</sup> The position, generally fulfilled by a nurse or other supportive care personnel, ensures that there is continuity throughout the care process, including communication of the treatment plan to the patient and coordination of all necessary care.<sup>22</sup> The NBCC Demonstration Project illustrated the important role that breast care nurses play as coordinators of care and facilitators of effective communication amongst the team and with patients.<sup>1</sup> Evidence continues to emerge that the care coordinator position has the potential for improving the patient’s cancer experience.<sup>23</sup>

### **MULTIDISCIPLINARY CARE IN AUSTRALIA: A NATIONAL DEMONSTRATION PROJECT IN BREAST CANCER**

#### **THE ONCOLOGY NURSE OR CARE COORDINATOR**

A principle conclusion drawn from the NBCC Demonstration Project is that the presence of a breast care nurse in a multidisciplinary team is beneficial both for the woman and the clinicians. While this model of care may not be directly transferable to other cancers, it is appropriate to identify the health care professional who is responsible for coordinating the patient’s care and identifying psychosocial issues.

In the NBCC Demonstration Project, the breast care nurse enhanced continuity of care and communication about treatment, as well as the recognition by other clinicians of psychosocial issues and the need for appropriate referral.

## Establishing a team identity

*“we all belong to one team ... a new tribe ... it's facilitated all sorts of communication ...”*

It is important that a multidisciplinary team identity is established. Practical examples of how to promote team identity may include:

- developing a team name and agreed values
- displaying posters identifying team members in public areas
- developing a team identifier such as a logo and letterhead (taking account of local protocols regarding the use of logos)
- providing regular team updates via email or a 'bulletin board' for team communication.

It is also important to establish a communications framework that supports the team and ensures interactive participation from all relevant team members at regular and dedicated case conference meetings. In selecting a name for the team, consideration should be given as to how the team and its function will be explained to patients. Select phrases such as 'patient care team', rather than 'multidisciplinary team', which may be confusing for patients (see page 30). It is also important for all team members to be aware of, and agree on, the purpose of the team and its meetings from the outset (see page 18).

### CASE STUDY: ESTABLISHING A TEAM IDENTITY

**THE CHALLENGE:** During the NBCC Demonstration Project, the need to develop an identifiable team and strengthen links between members was identified.

**THE SOLUTION:** Diagrammatic representations of clinical management pathways were developed for each hospital site and posters summarising these pathways, including photographs of team members, were displayed in relevant waiting areas. Meetings with all clinicians from across the Collaboration were held early during the set-up phase to emphasise the benefits of a multidisciplinary approach and promote the use of the clinical management pathway. A logo was developed specifically for the Collaboration and used on letterhead distributed to all relevant facilities in the region during the implementation of strategies.

## Multidisciplinary meetings

*“people come spontaneously now ...  
it’s a self-perpetuating activity ...”*

Regular team meetings are an integral component of MDC. A central theme of meetings should be prospective treatment planning. Benefits of regular treatment planning meetings include professional development activities, development of local protocols and discussion of other relevant issues such as resolving service delivery problems. Once the team is established it may be appropriate to hold meetings outside the usual MDC treatment planning meetings to discuss specific topics of interest or for professional development. Using the meetings as an educational and information-sharing opportunity, as well as for treatment planning, can help both to encourage attendance and ensure sustained interest.

### **MINIMUM CONDITIONS FOR MULTIDISCIPLINARY TREATMENT PLANNING MEETINGS**

As a result of the Observational study of MDC that accompanied the NBCC Demonstration Project, the NBCC has outlined the minimum set of conditions required for effective multidisciplinary case conferencing.<sup>1</sup> These are listed below:

- respected peer leader with strong leadership and facilitation skills to enable full participation of all disciplines
- supporting infrastructure (eg meeting room venue, facilities, equipment)
- preparation of all relevant materials and information in advance of meetings
- inclusion of all disciplines and mutual respect between participants leading to productive group dynamics
- incentives for participants to attend meetings (eg education, evidence of benefits, food)
- timely communication of the outcomes of case discussions to the patient, and to his/her general practitioner.

Practical advice regarding each of these factors is provided throughout this guide.



# PLANNING A MULTIDISCIPLINARY MEETING

## Setting up a new meeting

When establishing regular multidisciplinary meetings for a new team, it is important to gain consensus from all team members on the team responsibilities, meeting aims and frequencies and local protocols for issues such as decision making, documentation processes, providing feedback about meeting outcomes, confidentiality and consent. This planning phase may involve several meetings between team members and should be facilitated by a respected peer. It is important throughout this process to emphasise the benefits of the multidisciplinary process in order to encourage participation (see page 33). If possible, hold initial planning meetings at a time that is likely to be used for future treatment planning meetings in order to promote familiarity of timing amongst the team. Use these planning meetings as an opportunity to assess current strengths and achievements of the hospital/department as well as to identify areas for improvement or development. If a number of areas for development are identified, it may be necessary to prioritise these, with the aim of working on only one or two at one time.



## Team leadership and coordination

“(the champion) has strong links with all people in the team ... she’s one of these enthusiastic people that every team needs ...”

Team leadership has been identified as a key aspect contributing to successful and sustainable MDC meetings.<sup>1,2,9</sup> Leadership and coordination may take a number of forms:

- a **‘champion’** who drives initiatives and is integral in gaining and maintaining support for the meetings; this role is particularly important during the early stages of a team’s formation
- a **meeting chair** who facilitates discussions during team meetings (see page 26)
- a **meeting coordinator** who coordinates the logistics for meetings (see page 20).

These roles require energy, enthusiasm and an ability to communicate with, and gain input from, other team members. Each role may be undertaken by one or more individuals or multiple roles may be fulfilled by one individual. However, once the roles are allocated it is important that role definition is agreed upon at the outset and that other team members are aware of which team member is responsible for which aspects of meeting organisation and coordination. It is also important to have agreed team members to act as ‘back-up’ for these roles if the primary contact is not available. For further information about team communication see page 27.

### TEAM CONTACT LIST

ROLE	MAIN CONTACT	BACK-UP
Meeting coordinator		
Meeting chair		
Other		
Other		

## Meeting coordinator

Roles of the meeting coordinator include identifying patients for discussion during the meetings, organising meetings, collating information and ensuring availability of relevant information sources (see page 22) for presentation at meetings, recording outcomes of case conference discussions and informing the treating clinician and/or the patient's general practitioner of the meeting outcomes. If available, administrative personnel can undertake the role of meeting coordinator. However, in the absence of administrative personnel, the role of meeting coordinator may be undertaken by another meeting attendee, such as an oncology nurse, data manager or registrar. At larger centres, registrars may take responsibility for coordinating meetings on an alternating basis. Regardless of who fulfils this role it is important that all team members are aware of who is undertaking the role and that a back-up is available in situations where the primary coordinator is unavailable.

## Timing of meetings

*“it's just one of those communal culture things where everyone just accepts that ... on Friday it's the MDC meeting ... it's just part of the week ...”*

The NBCC's Sustainability of Multidisciplinary Care Study<sup>2</sup> has demonstrated that a key to sustainability of MDC meetings is for them to become habitual. With this in mind, meetings should be held at the same time and place to maintain routine and avoid confusion. The duration of MDC meetings will be determined by the size of the institution and the number of cases requiring discussion. In general it will be appropriate to limit the meetings to 45–90 minutes. Any time not used for treatment planning may be used for educational purposes or discussion of other relevant issues. Meetings should be held at a time convenient for all attendees – it is important to canvass the opinions of all attendees to ensure a mutually acceptable time. Meeting times should be planned to take account of attendance by off-site personnel. In regional and rural areas it will be important to hold meetings to coincide with visits by Visiting Medical Officers or at a time convenient for these attendees to be present via teleconference or videoconference. It may be appropriate to hold meetings over breakfast before the start of the working day, over lunch or at the end of the day.

## Venue and resources

Generally, hospital meeting rooms can be used as venues for MDC meetings. It is important that the chosen venue has sufficient space for all participants and that there is adequate access to power points so that equipment such as projectors and light boxes can be used. Ideally, the room set-up should allow team members to face each other, eg in a 'round-table' format. The checklist below will help you to select what equipment and resources are required for your meetings. If you are setting up a new meeting consider sharing equipment with other departments or groups to amortise costs.

Provision of refreshments at meetings can be important, particularly if meetings are held outside normal working hours, during breakfast or lunchtimes or towards the end of the working day.

### CHECKLIST OF SUGGESTED MEETING RESOURCES

RESOURCE	WHERE FOUND	WHO RESPONSIBLE
Light box		
Overhead projector		
Slide viewer, microscope and projector		
Videoconference facilities		
Telephone with speaker (if teleconferencing)		
Refreshments		

## Participants

All core team members should attend MDC meetings. The general practitioners of patients due to be discussed at a meeting should be informed of the meeting and encouraged to attend in person or by teleconference. Alternatively, a general practitioner liaison officer may be appointed by the local Divisions of General Practice to represent and provide feedback to general practitioners who have patients being treated by the MDC team. If unable to attend, follow-up after the meeting will be important (see page 24). In regional and rural areas, meetings should be timed to allow attendance either in person or via tele-/videoconference by appropriate Visiting Medical Officers. Non-core team members should be aware of the regular meeting day and time and should be invited in advance if their input on specific cases is required. Other non-participatory attendees may include medical students or visiting health care professionals. It is important to note that although the *Principles of Multidisciplinary Care* emphasise the importance of involving the patient in discussion about the treatment plan, the patient does not have to be in attendance at the treatment planning meeting itself. More important is the need to ensure protocols are in place to ensure that patient preferences are considered in developing the plan and that the outcomes of the meeting are discussed with the patient who agrees the final treatment plan.

## Deciding which patients to discuss

All patients with a newly diagnosed cancer should be discussed by the multidisciplinary team. However the level of discussion may vary depending on both clinical and psychosocial factors. Some cases may only require brief discussion while others will require more detailed review and comment. There may also be a need to review existing treatment plans for patients who have been discussed previously. Local protocols to guide the decision-making process should be agreed by the team.

## Information sources

Good preparation of materials and information in advance of multidisciplinary meetings is essential. The types of materials and information required at a meeting will vary according to tumour type but are likely to include all relevant medical history details, pathology reports and slides, imaging films and scans, results of diagnostic examinations, blood test results and previous treatment plans if relevant. The patient's medical history and diagnostic results can take the form of a 'patient summary' prepared prior to the meeting and disseminated to all team members. This task may be assigned to one of many team members, including registrars.

Information about the patient's concerns, preferences and social circumstances should also be presented at the meeting, for example by the oncology nurse (or care coordinator if available) or by the treating physician. It is also appropriate to have access to relevant clinical practice guidelines and other evidence-based information at the meetings.

Collection of relevant information in advance and presentation of results is a task that can be designated, for example, to one or more surgical registrars who regularly attend the meetings. Alternatively, individual clinicians can take responsibility for bringing relevant information to the meetings regarding their own patients. Whichever system is chosen, it is important that the team agrees upon the designated responsibilities from the outset and that back-up plans are in place in case of non-attendance.

## REGISTER OF INFORMATION SOURCE PROVIDERS

INFORMATION SOURCE	PRIMARY RESPONSIBILITY	BACK-UP
Pathology slides and reports		
Imaging films and reports (radiology, nuclear medicine)		
Blood test results		
Patient files		
Patient preferences/priorities and social circumstances		
Patient summary		
Treatment plan (if previous plan being reviewed)		
Other		
Other		

## Involving off-site attendees

It will not always be possible for all team members to be present at one site. In regional sites, it may be appropriate to plan meetings at times when a visiting specialist is due to be present. For other sites, issues of distance may be overcome using teleconferencing or videoconferencing<sup>24</sup>. If off-site attendees are to be included in meetings it is important to ensure that they have access to slides, scans and other visual information that will be presented at the meeting. This may involve scanning X-rays in advance of the meeting and sending documents via email to distant sites. Issues with technology can often be frustrating in such situations and it is useful to identify an individual with information technology skills to provide troubleshooting support for the meetings.

If meetings do involve off-site attendees it is also important that all team members are aware of teleconference and videoconference protocols, ensuring that individuals contributing to discussion identify themselves when speaking, that off-site attendees have access to the same information as on-site attendees and that their contribution to discussions is encouraged.

It is also important to establish a process for informing relevant general practitioners of the meeting times to encourage attendance as appropriate. The needs of off-site attendees should be taken into account during the initial set-up phase to facilitate attendance.

## CASE STUDY: IMPLEMENTING TELECONFERENCING

**THE CHALLENGE:** Lack of access to a full multidisciplinary team in a remote area.

**THE SOLUTION:** Regular meetings via teleconference.

**ISSUES RAISED:** How would the new technology be accepted by clinicians involved in a teleconference? Would this create additional work or necessitate a change in practice which would compromise the establishment of a regular meeting? Could a convenient time be found and would the meeting participants see the benefit, which would encourage ongoing attendance?

**THE RESULT:** Clinicians identified the problem and telemedicine was presented as a solution. A 'champion' was identified at each end of the link who was committed to the process and who would encourage colleagues to attend. The telemedicine link was added to a regular team meeting so that the meeting occurred in the telemedicine room as standard practice regardless of whether a link by teleconference was planned. Pathologists and radiologists joining the teleconference were provided with images in advance of the meeting so that they could evaluate them before providing comment.

## After the meeting

It is important that systems are in place to promptly inform team members who were not able to attend the meeting about outcomes, such as the patient's general practitioner or referring clinician. Follow-up with the general practitioner should be via letter and may also include a telephone call or a follow-up meeting with the general practitioner. It is also vital to ensure that responsibility is allocated to a specific individual to ensure that the outcomes of the meeting are conveyed to the patient (see page 31).

**CHECKLIST FOR PLANNING A MDC MEETING – PRE-MEETING.**  
(Adapted from *Improving communication within the multidisciplinary team* <sup>25</sup>)

---

**a) Management**

- Identify a leader.
  - Schedule a planning meeting/process.
- 

**b) Name**

- Decide what the meeting will be called (eg 'patient care team' as opposed to 'multidisciplinary team').
  - Consider a team identifier, eg name and letterhead.
  - Get consumer input.
- 

**c) Agree time, location and resources**

- Decide on an appropriate venue and time.
  - Determine what audio-visual equipment is necessary.
  - Determine catering needs.
  - Identify local privacy/confidentiality requirements.
- 

**d) Goals**

- Identify the team's aims and expected outcomes – both short- and long-term goals.
- 

**e) Membership**

- Specify who is involved in the meeting. Supply all team members with a comprehensive directory of participants of meeting with contact numbers, expertise and roles.
- 

**f) Facilitation/chairing**

- Identify and train a meeting chairperson. The leader/'champion' may not necessarily be the most appropriate person to chair the team meeting.
  - Training in negotiation and communication skills may be helpful.
- 

**g) Practicalities**

- Discuss interruptions/phonecalls and protocols dealing with interruptions.
  - Ensure that all relevant reports (pathology, surgery, radiology etc) will be brought to the meeting and responsibility for this is delegated appropriately.
  - Provide patient summaries.
  - Ensure new members are introduced to the group.
- 

**h) Documentation**

- Develop common documentation of a written treatment plan.
  - Decide what should go into medical records and determine privacy issues in psychosocial and genetic information. There is a need for each team to refer to their local and State/Territory guidelines.
  - Develop patient summaries for each patient.
  - Establish data collection (for long-term analysis and review).
- 

**i) Tools**

- Discuss the use of shared forms, history taking (including medical history), exam findings, medication etc and who is responsible for this.
- 

**j) Outcomes**

- Discuss the method of reviewing patient and meeting outcomes and evaluation – eg annual statistics, patient satisfaction surveys, unmet needs, survival data, team satisfaction, waiting times.
-



# RUNNING A MULTIDISCIPLINARY MEETING

## Role of the chair

Good leadership and facilitation are key factors in the success of multidisciplinary meetings. The Chair does not have to be the same person in every meeting, as long as the leadership and facilitation roles are fulfilled. You may wish to consider having the role shared between several team members. A study of breast care teams in the United Kingdom<sup>9</sup> found that the most effective team meeting outcomes were from teams that shared the leadership role for clinical decision-making, that is 'plural, democratic, or distributed leadership'.

All Chairs should be aware of the need for strong leadership. It is important to recognise that this does not equate to dominance of clinical decision-making. Rather, the Chair's role is to facilitate participation by all members of the multidisciplinary team in clinical discussions and decision making, and to ensure that meetings are not dominated by a few clinicians.

### ROLES OF THE CHAIR:

- keeping meetings to the agenda
- commencing discussions
- prompting the full range of input into discussions if it is not forthcoming
- summarising the discussion and inviting any further input before moving to the next case
- negotiating resolution of conflict if necessary
- promoting mutual professional respect among all team members.



## Managing group dynamics

*“there’s now substantially more trust, less fear of critical comment [in the MDC meetings] ... people now bring in cases of difficult decisions and review very critically what’s gone on in the past and what should go on in the future ... ”*

Mutual respect and good group dynamics are important factors in effective MDC meetings. It is important that each participant’s input into discussions is valued and respected by the other participants. Clarification and understanding of each team member’s role within the team is an important aspect of team membership. To assist in clarifying team roles and role boundaries it may be beneficial to:<sup>1</sup>

- clarify role perceptions and expectations of each other
- identify your own and other professionals’ competencies
- explore overlapping responsibilities
- re-negotiate role assignments.

## Communication skills training

Effective communication between health professionals is vital but may be difficult with an expanded team of professionals. For multidisciplinary teams to be effective, all members must communicate effectively with one another. Inadequate communication between members of cancer teams can lead to confusion for patients about diagnosis, prognosis, and treatment plans.<sup>1</sup> Findings from the NBCC Demonstration Project indicated that improving communication among multidisciplinary team members may be one of the most important factors in ensuring women feel that they are receiving care from a coordinated team.<sup>1</sup>

You may wish to consider undertaking communication skills training as a team. The NBCC, in collaboration with The Pam McLean Cancer Communications Centre, has developed a module that focuses on improving the communication skills of health professionals within an MDC team. The module, *Improving communication within the multidisciplinary team*,<sup>25</sup> is based on the NBCC’s *Principles of Multidisciplinary Care* and is relevant for all cancers.<sup>22</sup> For further information about communication skills training opportunities see page 36.

## Treatment plan

*“I feel like I’ve internalised it [the process] so that if I had a breast cancer patient, I would not have completed the treatment planning without presenting them [at an MDC meeting] ...”*

Development of a tailored individual treatment plan, informed by the pooled experience of all multidisciplinary team members, that considers the full range of treatment options available to the patient together with patient preferences, allows the clinical pathway to be more streamlined for the patient and keeps all team members better informed. The treatment plan should be a formal, written plan that organises the work of the team and helps patients to navigate the steps involved in their treatment and identify where they are in the process. The plan should consider both the treatment options and the psychosocial needs of the patient. You may wish to develop a proforma that reflects the relevant treatment pathway. A generic treatment plan that can be adapted for specific tumour types can be found in Appendix C.

A number of steps have been identified to assist the multidisciplinary team in effective decision making when developing the treatment plan:<sup>26</sup>

- clarify roles and involvement by relevant multidisciplinary team members in the decision-making process
- ensure sufficient and relevant data are presented about the diagnosis through the use of a synoptic report that provides a summary of the essential diagnostic information
- consider all relevant treatment options
- consider psychosocial status and support needs
- identify responsibilities for actioning and communicating the agreed treatment plan.

## Documentation

It is important to identify a common documentation process from the outset. The style of documentation should suit all team members. You may consider using a grid where details from the meeting are filled in by all team members.

Documentation can also support accreditation activities at the local level. Regular recording of attendance, frequency of meetings and decisions made provides a record of the multidisciplinary process. Associated clinical audit processes can also assist in the collection of clinical indicator data for the purpose of quality improvement.

## Evaluating multidisciplinary care

You may choose to evaluate the status and performance of the MDC team at intervals. This should be possible if a formal documentation process has been followed. For example, the Department of Human Services in Victoria has developed performance indicators for MDC in breast cancer to assist in this process. See page 36 for details of how to access this information.

### **CHECKLIST FOR RUNNING A TEAM MEETING.**

**(Adapted from *Improving communication within the multidisciplinary team*<sup>25</sup>)**

#### **a) Agenda**

- Generate a meeting agenda. Distribute the agenda in advance and circulate background material. Stick to the agenda.
- 

#### **b) Internal dynamics**

- Discuss conflict resolution methods, including ways to deal with absenteeism, phone calls, members who dominate the meeting.
- 

#### **c) Personal communication skills**

- Increase individual skills as a communicator and make use of relevant guidelines – for example *Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer*.<sup>27</sup>
  - It may be beneficial to undertake communication skills training as a team.
- 

#### **d) Social time**

- Foster relationships which ensure the team works better together.
- 

#### **e) Schedule continuing education for the team**

- Journal clubs may be one way of ensuring professional development.
- 

#### **f) Follow-up**

- Establish protocols for timely communication after the meeting. Phone calls and letters should be discussed – ie the best time to contact and the preferred medium of contact.
- Fax-back forms to general practitioners and team members may facilitate efficient communication.



## KEEPING THE PATIENT INFORMED

*“with MDC meetings ... the women (with breast cancer) feel that they are being included as a team member ...”*

### Explaining the concept of multidisciplinary care

Orientation of patients to the concept of MDC is generally provided by the oncology nurse or treating clinician. The designated individual should define the term ‘multidisciplinary’. It is important to be aware that this term can be ambiguous to some patients. One study conducted in Victoria<sup>28</sup> found a lack of understanding and acceptance of the term by patients, as it conveyed negative associations of childhood discipline. Alternative names include ‘patient care team’ or ‘care team’. The concept of the team should also be introduced to patients and permission sought from the patient for discussion of their case at team meetings.

All patients should be provided with written information about the members of their multidisciplinary team, what and how information is shared between team members and the treatment plan.<sup>29</sup> This can be achieved through the development of:

- a brochure explaining the full range of health professionals involved in the patient’s care
- a map of possible care pathways
- a photo of team members or list of names
- a prompt sheet for patients to assist them in obtaining all information during consultation with other health professionals.

It is important to explain to the patient how the meetings work, the meeting structure, whether or not patient names are used in the meeting and issues relating to patient confidentiality.

## Consent

It is important that patients understand that the MDC process means that their case may be discussed with clinicians who they have not yet met. Consent from patients should be obtained in line with local protocols regarding consent for the disclosure of and use of personal information in the health environment. It is important to identify the level and type of consent required – eg written or verbal consent – at your hospital/clinic, who is responsible for obtaining consent, and to ensure all team members are aware of consent requirements.

## Communicating meeting outcomes to the patient

Research has found that the mental health and well-being of adults with cancer can be improved through the provision of adequate information,<sup>27</sup> and most patients prefer to be involved in decision-making about their own treatment.<sup>27</sup> It is important for the team to establish a process for communicating case discussion outcomes and recommendations to the patients and their general practitioners.

During the meeting, the team should discuss informing the patient about prognosis and who is responsible for this. Work out the best way for communicating with different individuals and what information is required by others in phone calls, letters as well as face-to-face meetings.

## CHECKLIST FOR COMMUNICATING WITH THE PATIENT

(Adapted from *Improving communication within the multidisciplinary team*<sup>25</sup>)

### a) Pre-team meeting

- Address orientation issues for the patient. Discuss whether a brochure explaining clinicians involved in the patient's care may be appropriate.
  - Discuss whether the patient's name will be used in the meeting and issues of patient confidentiality.
- 

### b) Team meeting

- Discuss in the meeting what the patient will be told about treatment options, prognosis and who is responsible for this etc.
  - Discuss whether an 'I' or 'we' form of self-reference will be used.
- 

### c) Need for orientation for the patient

- Initial clinician introduction: After explaining your role in the patient's care, introduce the concept of the team and seek patient permission for discussion of your case at team meetings. Consider:
    - Consent
    - Privacy. This should be brought up at this time and any concerns the patient has about this. Written consent should be discussed with the patient and the team.
    - Map
    - Brochure
    - Photo of team or list of names
    - Aims
- 

### d) Prompt sheet

- Consider the use of a question prompt sheet for the patient to assist in obtaining all necessary information during consultations with other health professionals.
  - A number of prompt sheets are available in the literature. Development of a prompt sheet as a team may be beneficial. The sheet could be included in the information that is provided to the patient perhaps by the oncology nurse, care coordinator or the first point of contact. Ensure team members are aware of the sheet and actively ask patients if they would like to use it.
- 

### e) After the meeting

- Discuss mechanisms of informing the patient of participating team members and the treatment plan.
  - Relay changes and final decisions back to other team members. Work out the best way for communicating with different individuals and what information is required by others in phone calls, letters as well as face-to-face.
  - Follow-up on outcomes for difficult cases.
  - Consider a template letter/form for follow-up with for general practitioners.
-



# MAKING MULTIDISCIPLINARY CARE WORK

## Managing change

The success of strategies to implement or improve MDC will depend on the willingness of team members to change established processes and adopt new working practices. This process will be facilitated by ensuring that team members have an understanding of the benefits of the new processes being implemented. It may be valuable to seek assistance from other groups who have already established regular meetings, with the aim of providing practical advice about overcoming particular barriers. Setting milestones as a team and reviewing progress at intervals will also ensure ongoing engagement in the process by team members. Ultimately the goal will be to embed the culture of MDC into everyday practice so that meetings become habitual and team decision making occurs as a matter of course.

## Benefits to team members

*“when the plan of management is sanctioned by a committee, it’s a comfortable thing ...”*

*“I think [MDC] is really driving itself ... [the clinicians] want to see the benefit of it, they will state that openly, and I think they enjoy coming to the meetings ...”*

Research from the United Kingdom has found that clinicians who work as part of a breast cancer care team have a significantly lower incidence of minor psychiatric morbidity than in the general health care workforce and in samples of the general population.<sup>9</sup> In the NBCC Demonstration Project and Observational Study, participants’ perceptions of the many benefits to themselves and their patients of the multidisciplinary case conference meetings were a key motivating factor in ensuring ongoing attendance. In setting up multidisciplinary meetings it is important to emphasise the benefits of attendance in terms of problem sharing, joint decision making, education and peer interaction.

Several participants in the NBCC Demonstration Project clearly placed considerable value on the educational aspect of the case conference meetings. Participants also believed that discussions about evidence resulted in good, up-to-date, evidence-based treatment plans for patients that were more likely to be suited to the individual patient’s needs, and free from the biases of individual clinicians.

Participants reported that the meetings made it easier for them to do their job well, as they already had some knowledge of patients before meeting with them, and they knew other members of the multidisciplinary team, making the referral pathways easier. Streamlining the clinical pathway was also perceived as a benefit to the patients.

## Sustainability

*“now people don’t want to miss a meeting ... it would take a lot to threaten the sustainability of the meetings ...”*

*“[the meetings] will continue because they are very much a part of [the clinicians’] practice – the team is dependent upon the meetings for decision-making ...”*

The NBCC’s follow-up Sustainability Study of health services participating in the NBCC Demonstration Project indicated that MDC is sustainable with adequate funding and resources.<sup>2</sup> Flow-on effects of the MDC strategies into the management of patients with other cancers or other chronic diseases were also apparent. Cultural changes across health care services, such as improved communication between disciplines and acceptance of shared clinical decision-making, were other indirect outcomes of MDC strategies implemented during the NBCC Demonstration Project. The study demonstrated the importance of the following factors in ensuring sustainability:

- allocating dedicated funds and personnel to maintain, support and improve MDC strategies
- ensuring MDC case conference meetings are held routinely, so that meeting preparation and participation become habitual for participants
- ensuring that MDC team members recognise the MDC strategies to be beneficial for patients and/or themselves
- encouraging commitment to participation in MDC case conference meetings by participants, through demonstration of the benefits
- enlisting a ‘champion’ – usually a well-respected clinical opinion leader – to drive the MDC strategies, particularly in the early stages, although this also needs to be supported by team ownership to ensure sustainability in the longer term
- developing contingency plans to allow for changes in personnel and organisational structure.

Support from senior health administrators for MDC assists with both establishing MDC teams and ensuring their ongoing sustainability.



**MULTIDISCIPLINARY CARE IN AUSTRALIA:  
A NATIONAL DEMONSTRATION PROJECT IN BREAST CANCER  
COSTS OF IMPLEMENTING MULTIDISCIPLINARY CARE**

The NBCC Demonstration Project identified the following aspects of the costs of implementing MDC:<sup>1</sup> These include:

- The cost of implementing MDC strategies was dependent on the level of multidisciplinary initiatives already in place at a facility. Costs were higher for newly established strategies compared with adaptation of existing strategies.
- Significant personal time was needed to implement new strategies such as treatment planning meetings.
- The cost of staff attendance at case conference and educational meetings was dependent on the number and type of attendees and the length and frequency of meetings.
- The average cost per meeting and per case presented at multidisciplinary case conference meetings tended to decrease as meetings became better established. The use of existing facilities, such as hospital meeting rooms and equipment from other groups, reduces the overall cost.
- Capital and equipment costs can be reduced by sharing the costs between different departments and disciplines.

**MULTIDISCIPLINARY CARE IN AUSTRALIA:  
A NATIONAL DEMONSTRATION PROJECT IN BREAST CANCER  
BARRIERS TO IMPLEMENTING MULTIDISCIPLINARY CARE**

Barriers encountered in the implementation of MDC strategies included: resistance to change; lack of time, resources and clinical staff; and the challenge of covering large geographical areas.

In overcoming these barriers, the NBCC Demonstration Project identified several key resource requirements for MDC:<sup>1</sup>

- local clinical opinion leaders acting as advocates for MDC are crucial in lobbying staff and overcoming initial resistance and promoting cultural change
- the difficulty of changing long-established practice patterns should not be underestimated and should be addressed with evidence of benefits from new approaches
- administrative staff can greatly reduce the workload of clinicians in the set-up and coordination of meetings
- support is needed from senior hospital administration in providing meeting infrastructure such as an appropriate venue and equipment, including telecommunications assistance to overcome the challenge of meeting together and geographical remoteness.



## FURTHER INFORMATION

The NBCC website has a dedicated multidisciplinary component that provides the latest information on implementing and improving sustainable MDC for all cancers in Australia. The website includes a range of resources to support MDC, as well the latest updates to this guide.

For further information: [www.nbcc.org.au/mdc](http://www.nbcc.org.au/mdc)

The NBCC has developed a series of evidence-based modules that provide a summary of the relevant research and guidelines about how best to address issues when communicating with patients diagnosed with cancer. The existing modules address the topics of:

- general interactional skills
- telling a woman she has breast cancer, a recurrence or metastases
- effectively discussing treatment options
- preparing patients for potentially threatening procedures and treatment
- dealing with angry patients
- dealing with anxious patients
- effectively discussing prognosis
- improving communication within the multidisciplinary team
- discussing transitions from curative care through to palliative care
- communicating with younger women diagnosed with breast cancer.

For further information National Breast Cancer Centre [www.nbcc.org.au](http://www.nbcc.org.au)

BreastCare Victoria, Department of Human Services has produced a number of resources to support MDC including:

- Multidisciplinary Toolkit
- E-Health information and resources including practical advice for videoconferencing.

For further information: [www.health.vic.gov.au/breastcare/pubs/resources.htm](http://www.health.vic.gov.au/breastcare/pubs/resources.htm)

The NBCC module on improving communication within the multidisciplinary team was developed by The Pam McLean Cancer Communication Centre (PMCC). The PMCC teaches health professionals to communicate effectively and compassionately with patients and fellow practitioners.

For further information: <http://www.mcleancentre.org>



## REFERENCES

1. National Breast Cancer Centre. *Multidisciplinary Care in Australia: a National Demonstration Project in Breast Cancer*. Camperdown: National Breast Cancer Centre, 2003.
2. National Breast Cancer Centre. *Sustainability of Multidisciplinary Cancer Care*. Camperdown: National Breast Cancer Centre, 2004.
3. Australian Institute of Health and Welfare (AIHW) 2004. *Australia's Health 2004*. AIHW, Canberra, ACT.
4. National Health Priority Action Council. *National Service Improvement Framework for Cancer*. 2004.
5. Chang JH, Vines E, Bertsch H, Fraker DL, Czerniecki BJ *et al*. The impact of a multidisciplinary breast cancer center on recommendations for patient management. *Cancer*, 2001; 91(7): 1231-1237.
6. National Breast Cancer Centre. *Clinical practice guidelines for the management of early breast cancer: 2nd edition*. National Breast Cancer Centre, Woolloomooloo, 2002.
7. NHMRC National Breast Cancer Centre. *Clinical practice guidelines for the management of advanced breast cancer*. National Breast Cancer Centre, Woolloomooloo 2001.
8. Richardson GE, Thursfield VJ, Giles GG for the Anti-Cancer Council of Victoria Lung Cancer Study Group. Reported management of lung cancer in Victoria in 1993: comparison with best practice. *Med J Aust* 2000; 172: 321-324.
9. Haward R, Amir Z, Borrill C, Dawson J, Scully J, West M, Sainsbury R. Breast cancer teams: the impact of constitution, new cancer workload, and methods of operation on their effectiveness. *Br J Cancer*. 2003;89(1):15-22.
10. Gabel M, Hilton NE, Nathanson SD. Multidisciplinary breast cancer clinics: do they work? *Cancer* 1997;79: 2380-2384.
11. Barr O. Interdisciplinary teamwork: consideration of the challenges. *British Journal of Nursing* 1997;6(17):1005-10.
12. Fergusson RJ, Gregor A, Dodds R, Kerr G. Management of lung cancer in South East Scotland. *Thorax* 1996; 51: 569-745.
13. Billing JS, Wells FC. Delays in the diagnosis and surgical treatment of lung cancer. *Thorax* 1996; 51: 903-906.
14. Cancer Institute NSW. *The NSW Cancer Plan 2004-2006*. Sydney. The Cancer Institute NSW, 2004.
15. *Priorities for Action in Cancer Control 2001-2003*. Cancer Strategies Group. Canberra: National Health Priority Action Council, 2001.
16. House of Representatives Standing Committee on Community Affairs. *Report on the Management and Treatment of Breast Cancer in Australia*. Canberra: Australian Government Publishing Service, 1995.
17. Clinical Oncological Society of Australia, The Cancer Council of Australia and the National Cancer Control Initiative. *Optimising Cancer Care in Australia*. Melbourne: National Cancer Control Initiative, 2003.

- 18.** The Cancer Council Australia, Australian Cancer Network and the National Breast Cancer Centre. *A core strategy for cancer care: accreditation of cancer services – a discussion paper*. 2005, National Breast Cancer Centre, Camperdown, NSW.
- 19.** Sainsbury R, Hayward B, Johnston C, Round C. Influence of clinician workload and patterns of treatment on survival from breast cancer. *Lancet* 1995; 345:1265-1270.
- 20.** Gillis CR, Hole DJ. Survival outcome of care by specialist surgeons in breast cancer: a study of 3786 patients in the west of Scotland. *BMJ* 1996; 312(7024):145-8.
- 21.** Zorbas H, Barraclough B, Rainbird K, Luxford K, Redman S. Multidisciplinary care for women with early breast cancer in the Australian context: what does it mean? *Med J Aust* 2003;179(10):528-31.
- 22.** Yates P. Cancer care coordinators: realising the potential for improving the patient journey. *Cancer Forum* 2004;28:128-132.
- 23.** Goodwin JS, Satish S, Anderson ET, Nattinger A, Freeman JL. Effect of nurse case management of the treatment of older women with breast cancer. *Journal of the American Geriatrics Society* 2003;51:108-114.
- 24.** Delaney G, Jacob S, Iedema R *et al.* Comparison of face-to-face and videoconferenced multidisciplinary clinical meetings. *Australasian Radiology* 2004;48:487-492.
- 25.** National Breast Cancer Centre and The Pam McLean Cancer Communications Centre. *Improving communication within the multidisciplinary team*. Camperdown NSW: National Breast Cancer Centre, 2004.
- 26.** Mariano C. The case for interdisciplinary collaboration. *Nursing Outlook* 1989;37(6):285-8.
- 27.** National Breast Cancer Centre and National Cancer Control Initiative. *Clinical practice guidelines for the psychosocial of adults with cancer*. National Breast Cancer Centre, Camperdown, NSW. 2004.
- 28.** Scott CJ, Neil SL, Rodger A. Where did they get the term multidisciplinary? Consumers' descriptions of the multidisciplinary meeting. *Australasian Society of Breast Disease Scientific Meeting*. 18-23 September 2003. Gold Coast, Australia.
- 29.** Breast Cancer Network Australia. *Still Making a Difference: Summary of Recommendations*. Breast Cancer Network Australia, Camberwell, VIC, 2005.

# Appendix A

## Recommendations for multidisciplinary cancer care in Australia

The NBCC report *Multidisciplinary Care in Australia: a National Demonstration Project in Breast Cancer* makes the following recommendations to promote MDC as an integral part of national policy for cancer care:

1. That the *Principles of Multidisciplinary Care* developed for breast cancer be used as the basis for developing similar frameworks for other cancers and other chronic diseases requiring multidisciplinary input.
2. That a brief user-friendly guide for establishment, preparation and support for multidisciplinary meetings be developed for use by health service providers.
3. That the National Cancer Plan and National Service Improvement Frameworks should explicitly quantify:
  - efficiency dividends for institutions
  - service improvement implications for patients in order to promote the benefits of MDC.
4. That clinical outcome studies to establish the benefits of MDC for patients with other cancers and chronic diseases such as diabetes, within the Australian health care system, be encouraged in order to provide an evidence base for broader implementation of MDC.
5. That the role and effectiveness of breast care nurses is supported at all levels by:
  - informing health service providers of the benefits of the breast care nurse role in the provision of MDC
  - promoting the adoption of the core competencies currently being developed by the NBCC for the breast care nurse role to nurse training programs nationally
  - providing opportunities for nurses caring for women with breast cancer to access specialist training to support that role.
6. That the establishment and maintenance of MDC meetings must be adequately and explicitly resourced by health service providers. Affordability would be enhanced with broader application to other cancers and chronic diseases to amortise infrastructure costs. Areas in which generalisation is already occurring should be studied.
7. That hospital funding models and specialist and general practitioner payment schedules should be modified to support the implementation of MDC strategies, given their broad application across a number of chronic diseases.

# Appendix B

## National Breast Cancer Centre's *Principles of Multidisciplinary Care*<sup>1</sup>

### PRINCIPLE OF CARE

### OUTCOME

#### Team

- The disciplines represented by the core team should minimally include surgery, oncology (radiation and medical oncology), pathology, radiology and supportive care. The individual patient's general practitioner will be part of the team.
- In order to ensure that the patient has access to the full range of therapeutic options, the core team may be expanded or contracted to include services (may be off site) such as genetics, psychiatry, physiotherapy and nuclear medicine

The core team is established and known.

Referral networks established for non-core team specialist services.

#### Communication

- A communications framework should be established which supports and ensures interactive participation from all relevant team members at regular and dedicated case conference meetings.
- Multidisciplinary input should be *considered* for all patients with cancer, however, not all cases may ultimately necessitate team discussion.

Communication mechanisms are established to facilitate case discussion by all team members.

A local protocol is established for deciding which cases may not require team discussion.

#### Full therapeutic range

- Geographical remoteness and/or small size of the institution delivering care should not be impediments to the delivery of multidisciplinary care for patients with cancer.
- The members of the team should support the multidisciplinary approach to care by establishing collaborative working links.

Systems are established for ensuring that all patients have access to all relevant services.

Systems are established to support collaborative working links between team members.

## PRINCIPLE OF CARE

### Standards of care

- All clinicians involved in the management of patients with cancer should practice in accord with guideline recommendations.
- The treatment plan for a patient should consider individual patient circumstances and wishes.
- Discussion and decisions about treatment options should only be considered when all relevant patient results and information are available.
- In areas where the number of new cancers is small, formal collaborative links with larger units/centres should give support and foster expertise in the smaller unit.
- Maintenance of standards of best practice is supported by a number of activities which promote professional development.

### Involvement of the patient

- Patients with cancer should be encouraged to participate as members of the multidisciplinary team in treatment planning.
- The patient diagnosed with cancer should be fully informed of his/her treatment options as well as the benefits, risks and possible complications of treatments offered. Appropriate literature should be offered to assist his/her decision making. This information should be made available to the patient in a form that is appropriate to his/her educational level, language and culture.
- Supportive care is an integral part of multidisciplinary care. Clinicians who treat patients with cancer should inform them of how to access appropriate support services.
- The patient with cancer should be aware of the ongoing collaboration and communication between members of the multidisciplinary team about his/her treatment.

## OUTCOME

Local clinician data is consistent with national benchmarks.

The final treatment plan is acceptable to the patient, where possible.

Final reports are available to all core team members before treatment planning.

Systems are established for the exchange of knowledge and expertise between larger and smaller case load centres.

Systems are established for the support of professional education activities.

Patients are supported to have as much input into their treatment plan as they wish.

All patients are fully informed about all aspects of their treatment choices.

All clinicians involved in the management of patients with cancer ensure that patients have information about and access to support services.

Patients with cancer feel that their care is coordinated and not fragmented.

# Appendix C

## Generic treatment plan proforma

This form has been developed to provide an example of areas you may wish to include in your own tumour specific form.

<b>Meeting date:</b>	
<b>Patient particulars:</b> <i>Include name, address, date of birth etc as per local protocol</i>	<b>Consent:</b> <i>Record type of consent required and what was obtained</i>
<b>Managing clinician:</b>	
<b>Medical and family history:</b>	
<b>Diagnosis:</b> <i>Develop standard checklist relevant to tumour type.</i>	
<b>Pathology:</b> <i>For example</i>	
Type of tumour:	Nodal status:
Grade:	Stage: <i>For example T N M status</i>
Margins:	Hormone receptor status:
<b>Treatment Plan:</b> <i>Record recommended treatment plan developed by the MDC team. Develop standard checklist based on tumour type.</i>	
<i>For example</i>	
Surgery:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Chemotherapy:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type/length: _____
Radiotherapy:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Hormonal therapy:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Other: _____	
<b>Supportive care needs:</b>	
<i>For example</i>	
Supports:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Referral:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Concerns/issues:	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
<b>Patient preferences:</b>	
Are the patient preferences for treatment/management known: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Comment: <i>Changes to the plan following discussion with the patient</i>	
<b>Follow-up plan:</b>	
Discuss plan with patient	<input type="checkbox"/> No <input type="checkbox"/> Yes By whom: _____
Copy of plan sent to general practitioner:	<input type="checkbox"/> No <input type="checkbox"/> Yes By whom: _____
Copy of treatment plan placed in patient file:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other comments: _____	
Signature of person completing the plan: _____	

Thank you to the Austin Breast Care Unit and Strathfield Breast Centre for their assistance in developing this proforma.











**NATIONAL BREAST  
CANCER CENTRE**

Incorporating the  
Ovarian Cancer Program

**MULTIDISCIPLINARY MEETINGS FOR CANCER CARE:  
a guide for health service providers**

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