

MDC for advanced disease

The '[Multidisciplinary care principles for advanced disease](#)' (PAD) aim to improve care and quality of life of patients with advanced disease while maximising comfort and functioning. The PAD focus on the importance of continuity of care, coordination, and the involvement of the patients and their nominated caregivers, in the treatment and care planning process.

Advanced disease is defined as: cancer where the goal of treatment and care may not be cure, or where cure is not an option.

Improvements in cancer treatment for advanced disease mean that more patients are surviving longer and many receiving treatment and care. Every patient's cancer and care will be different. Some patients will live for many more years after a diagnosis of advanced disease, while others may only live for a short time. The needs and issues of these patients with advanced disease include:

- specific psychosocial issues including impact of diagnosis at an advanced stage, poorer prognosis and recurrence
- the management of physical symptoms and side-effects related to the spread of cancer and cancer treatments
- quality of life issues associated with disease progression
- practical issues and support for patients living with advanced disease.



Principles

The 'Multidisciplinary care principles for advanced disease' provide 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, across a range of health-care settings. A summary of the principles of advanced multidisciplinary care include:

- [patients](#) and their nominated caregivers, where appropriate, are involved in decisions about their care
- a [team approach](#), involving core disciplines integral to the provision of good care, including general practice, with input from other specialties as required
- provision of care in accordance with [nationally agreed standards](#)
- ongoing, timely [information and communication](#) is facilitated among all team members, including the patients and their nominated caregivers, throughout the cancer journey.

Patients

Patients and their nominated caregivers, where appropriate, are involved in decisions about their care

Principle of care	Outcome
a Patients with advanced disease and their caregivers, where appropriate, should be encouraged to participate as members of the multidisciplinary team in care planning	Patients and their caregivers, where appropriate, are provided with opportunities and supported to have as much input into their care plan as they wish Consent from the patient prior to communication among team members should be obtained according to local protocols
b The patient and their caregivers, where appropriate, should be fully informed of the treatment and care options, including the benefits, risks and possible complications of treatments offered and how to access appropriate support services to enhance quality of life	Appropriate information is offered to assist decision-making about treatment and care options and made available in a form that is appropriate to the patient's educational level, language, and culture
c The treatment plan for a patient should consider individual patient circumstances and wishes	The treatment plan is discussed with the patient and their caregivers, where possible, revised as appropriate, and recorded in patient's file Discussion and decision-making about management options is an ongoing and





Principle of care		Outcome
		dynamic process
d	Patient care is coordinated and not fragmented and the patient and their caregivers, where appropriate, are aware of the communication between team members	The patient and their caregivers, where appropriate, are regularly informed of the ongoing collaboration and communication between members of the multidisciplinary team about their treatment Patients' perceived expectations of their care needs are actively sought and met throughout their care

Team

A team approach involves disciplines integral to the provision of good care, with input from others, as required

Principle of care		Outcome
a	A multidisciplinary team approach to care should be considered for all patients with advanced cancer	A local protocol is established to ensure multidisciplinary discussion for all patients who present with advanced cancer; the patient and their caregivers, where appropriate, are informed of this
b	The cancer care team should be flexible to include health professionals from allied health, palliative and supportive care, community health, nursing and cancer clinicians, as required	The cancer care team for each patient is established and known by all team members including the patient, their caregivers and the MDC team agreed point of contact
c	The team leader and membership may change with the patient's changing needs over time, while maintaining a focus on optimising patient function and comfort throughout the disease	The team leader and membership are reviewed in consultation with patients and their caregivers to ensure appropriate care is offered and provided which meets the patient's changing needs

Communication and information

Ongoing, timely information and communication is facilitated among all team members, including the patients and their nominated caregivers, throughout the cancer journey.





Principle of care		Outcome
a	A communications framework should be established which supports and ensures interactive participation from all relevant team members at regular and dedicated case-conference meetings	Appropriate communication mechanisms are established to facilitate case discussion by all team members
b	Timely written communication between all health professionals including GPs is vital to providing optimal care	Systems are in place to ensure patients' results are made available to team members in a timely manner
c	End-of-life (EOL) planning is considered by members of the multidisciplinary team and support services are provided, encouraged and facilitated for all involved	Health professionals have access to appropriate training and support to enable them to appropriately manage EOL issues
d	As team membership and care setting (home, hospital, palliative care unit) may change during the course of the disease, communication between the MDC agreed point of contact, patient and caregivers is maintained	The patient and their caregivers are aware of who bears primary responsibility for their care and their agreed point of contact during the course of the disease

Standards of care

Provision of medical and supportive care is in accord with nationally agreed standards

Principle of care		Outcome
a	All health professionals involved in the management of patients with advanced cancer should practise in accord with guideline recommendations	Care is demonstrated to be consistent with national evidence-based recommendations and benchmarks, where relevant
b	Maintenance of standards of best practice is supported by a number of activities which promote professional development	Systems are established and monitored for the support of professional development
c	Location, type of service or patient's understanding of the health system should not be impediments to patient's access to MDC	Systems are established to support all patients with advanced disease to have access to MDC
d	The members of the team should support the multidisciplinary approach to care by establishing collaborative working relationships with appropriate local health care professionals	Systems are established to support collaborative working relationships and referral links
e	Use of supportive care services, including	Systems are established to provide patients





Principle of care

palliative care, and psychosocial interventions/support should be encouraged and facilitated

Outcome

with equitable access to all relevant medical and supportive care services



Patients

Supporting patients and their caregivers to participate

[Explaining the concept of 'MDC'](#) is an important part of introducing MDC to the patient and their caregiver. It is important to explain how meetings work, the meeting structure and any issues related to confidentiality.

The MDC team should ensure that both the patient's and caregiver's needs are met, wherever possible. Patients' and caregivers' perceptions about their cancer journey and interactions with health professionals may influence the treatment planning and care. Health professionals need to acknowledge this and be aware that the way they relate to, and communicate with, the patient and their caregivers may affect the way the patient and caregivers cope with the cancer. It also can affect the way caregivers resolve their grief following the death of the patient.

[See also - Keeping the patient informed](#)

[See also - Consent](#)

Caregiver's role

Caregivers are vital participants in the cancer journey. Caregivers are family members and/or friends identified by the patient who provide psychosocial and/or physical support to the patient throughout their disease. The role of caregivers should be discussed with the patient to ensure caregivers are involved, where appropriate. Information and support should also be offered to caregivers as required.

[See also - Treatment planning](#)

[See also - Coordination of multidisciplinary care](#)



Team

[The role of the MDC team](#) for advanced disease is to coordinate and provide treatment and care to patients, and provide information to support the emotional, physical, practical, financial, spiritual and social needs of patients and their caregivers. The needs of patients with advanced disease, and their caregivers will need to be regularly assessed, as their needs will change over the course of their disease.

Other health professionals may be called upon at different times during the patient's treatment course. For example, thoracic surgeons for pleural effusions, orthopaedic surgeons for an impending fracture or neurosurgeons for cord compression surgery.

- [Example of multidisciplinary team membership: advanced disease](#)
- [Example of multidisciplinary team membership: advanced breast cancer](#)
- [Example of multidisciplinary team membership: advanced ovarian cancer](#)

The patient's general practitioner

[The patient's GP](#) plays a pivotal role in the care planning for patients with advanced disease.

- [Case study: GPs and the multidisciplinary team](#)
- [Case study: involving GPs in a rural setting](#)





Communication and information

A communications framework

A [communications framework](#) should be developed which encourages and supports input into case discussion from all relevant team members.

Communication issues for health professionals

The shift towards [palliative care](#) represents a crucial step for patients with advanced cancer and their treatment team. Health professionals may find it challenging to communicate and manage this transition. Introducing palliative care as part of the team approach early after the diagnosis of advanced disease can facilitate this transition. Progression of disease may be rapid or may occur over a number of years with a series of recurrences and remissions. Contingency planning and thinking ahead will help health professionals create opportunities to discuss with their patients potential issues that may arise during the patient's disease. It is important to make clear to the patient that they will receive optimal care at all times and that this transition does not imply discontinuation of care or abandonment by their MDC team.

Guidelines about discussing disease progression recommend open and honest provision of relevant information. The patient and caregiver, where appropriate, should be told about changes to the cancer, treatment efficacy and prognosis, making sure enough time is provided to allow discussion of the implications of this information and the patient's emotional response and support needs. Teams should be encouraged to undertake [communication skills training](#) in order to improve the way they relate to other team members, cancer patients and caregivers.

The exchange of knowledge and expertise between larger and smaller teams should be encouraged. This gives health professionals the opportunity to improve outcomes for patients and work towards a best-practice approach to treatment and care.

End-of-life issues

Attitudes and perceptions about care, including end-of-life (EOL) and communication issues, are important aspects beyond clinical educational activities for health professionals. Health professionals involved in the care of people with advanced disease are encouraged to develop professional skills and to participate in regular reflective practice to ensure they can provide optimal care for their patients.

Choosing how and when to raise EOL issues with terminally ill patients can be challenging for health professionals. Overall, it is better to err on the side of ensuring that prognosis and EOL issues are accessible topics for patients and their families. Health professionals need to be sensitive about the way that they raise the subject and first explore the patient's understanding. When discussing EOL issues it is important for health professionals to balance hope and honesty.

Dealing with patients with advanced disease can be stressful for health professionals. This is especially so



when managing patients with EOL issues. It is important for health professionals to draw on the expertise of members of the MDC team in dealing with complex clinical problems. Debriefing and opportunities to access support services should also be made available to all team members.

[See also - Case study: discussing palliative care and end-of-life issues](#)

'Not for resuscitation' orders

Issues relating to 'not for resuscitation' (NFR) orders should be discussed with the patient and, where appropriate their caregivers. Issues that may arise from these discussions should be thoroughly documented.

For an Indigenous patient, the person or people that a hospital might consult to discuss NFR orders may be different. Particular kinship relationships can identify those who have primary responsibility for making NFR decisions.

NFR decisions should include discussions about being admitted into intensive care units and emergency departments and discussion about when cardiopulmonary resuscitation (CPR) may not be appropriate. CPR decisions will involve consultation between the patient, family, and relevant health care professionals.

[See also - Case study: discussing 'not for resuscitation' orders with patients](#)



Standards of care

Location of care

Care for patients with advanced disease will take place in a range of community-based settings outside of the hospital. These may include the patient's home, palliative care units, and/or residential care facilities. The MDC team should create links with specialist services and health professionals, especially those based in the community; these include community health nurses and community palliative care specialists.

Ideally, community-based services should be locally available and locally coordinated. Patients from regional and rural locations should benefit from their professional carers' networks to facilitate their MDC.

Supportive Care

Supportive care addresses a range of issues and needs for patients with cancer, including informational, emotional, spiritual, psychological, physical, practical, and financial needs. The role of supportive care is crucial in the management of patients with advanced disease. The supportive care needs of patients with advanced disease and their caregivers will be specific to the patient and their caregivers and will change over time.

Palliative care

Palliative care is care provided for people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life.

The aim of palliative care is to optimise the patient's comfort and levels of function. Palliative care stresses the importance of advanced planning with a focus on the whole person within their social and emotional context, rather than just the disease. Patients may experience a range of physical symptoms that will need to be managed, as well as the related psychosocial distress associated with having advanced disease. It is important for teams to assess the quality of life of their patients and take this into consideration when planning their treatment and care. MDC teams should aim to maintain function and quality of life for the patient throughout the course of their disease.

The term 'palliative care' is confronting for many patients, their caregivers and health professionals. Misconceptions about what palliative care involves, and its role in a patient's care, can influence a patient's decision as to whether they accept palliative care services as part of the MDC approach.

Palliative care is often seen as a service that is provided only at the end of life, but early referral can allow patients and their caregivers to benefit from a range of services and support.

For patients with complex needs the involvement of an interdisciplinary specialised palliative care service, working alongside primary clinical carers, is likely to be of benefit. A referral to palliative care services may be



made by the lead clinician, although some services will accept a referral from the patient, a family member or friend, a local community health centre or local hospital. The manner in which the referral is discussed with the patient and caregivers can help to avoid undue stress.

[See also - Case study: initiating a palliative care referral](#)

[See also - Case study: palliative care referral for advanced breast cancer](#)



Case studies

Multidisciplinary care for advanced disease

Case study: discussing palliative care and end-of-life issues with patients.

Challenge

The need to discuss with the patient issues associated with awareness and 'diagnosis' of a palliative state such as worsening symptoms, failure of treatments due to progressive disease or recurrent disease.

Solution

A discussion is held with the patient and palliative care team regarding timely assessment of symptom management, ability to manage illness, changing goals, wishes, and future needs. Discussions regarding EOL wishes, plans and goals are shared throughout the health care team and may be discussed at MDC meetings as planning processes. The discussions are then continued with the patients by members of the palliative care team who are known by the patient. The outcomes of conversations are shared with the entire MDC team to continue the communication process. Documentation of this plan is mandatory.

Outcome

Regular assessment and awareness of individual patient's disease and progression will lead to early and appropriate referral to the palliative care team. This will facilitate smooth transition into the palliative phase, thus allowing planning and respect of patient goals and wishes to be established.

Case study: discussing 'not for resuscitation' orders with patients

Challenge

A conversation is held with the patient at an appropriate time (individually determined by a senior clinician), to discuss 'not for resuscitation' (NFR) orders.

Solution



The initial discussion occurs at a time when the patient is not unwell or under stress (e.g. it is not appropriate when diagnosis is first given to them). It is explained to the patient that a discussion about NFR orders is best done before admission occurs. An explanation of the meaning of NFR and the processes involved with resuscitation is given. The issues relating to medical advice, appropriateness of treatment, the patient's right to choice and medical futility can be undertaken as needed. Written information will be provided to all. Admitting doctors should check the patient's 'NFR status' at each admission and ask the patient if they would like to change their status. It is suggested that their status is included in a card also recording their medications.

Outcome

The patient and their caregivers have the opportunity to be properly informed about this difficult and emotive topic. As a result, stress is reduced both for the patient and the family, as well as the doctors involved. This also avoids the distressing situation where a doctor unfamiliar with a patient, and their medical history, prognosis and other details, is required to determine the NFR status of a patient, often in the situation of the patient being acutely unwell.

Case study: initiating a palliative care referral

Challenge

Initiating a referral to palliative care.

Solution

Effective communication within the health care team to help determine appropriate and timely referral to the palliative care team is crucial. The referral is introduced to the patient and their carers by the designated care coordinator explaining the role of palliative care as one of active care that delivers specialised health care to maximise quality of life, whether that be symptom management, pain relief or spiritual, emotional, and psychological support.

Outcome

Introducing the discussion about palliative care is assessed within the MDC team on an individual basis dependent upon the patient's advancing illness and their hopes for the future.



Case study: palliative care referral for advanced breast cancer

Challenge

An advanced breast care nurse routinely assesses a patient's newly diagnosed with advanced breast cancer.

Solution

An advanced breast care nurse explains to the patient the role of key team members as providers of support, information, and symptom control. Once the patient is comfortable and aware of the value of this care, the advanced breast cancer nurse may suggest, if appropriate, that a similar support role can be provided in the community, also by a specialist nurse (from the community palliative care provider).

Outcome

Patients begin to separate the supportive care role of palliative care services, distinguishing them from terminal care. Patients become more accepting of supportive care provision in the community from palliative care services.

Case study: involving general practitioners

Challenge

Involving general practitioners in MDC.

Solution

To ensure that GPs participated in the planning phase, with a view to their participation in MDC 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 MDC meetings, they were enthusiastic about participating.

Outcome



GPs routinely attend the MDC 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 GPs who are to have patients discussed that week and through this mechanism, GPs are invited to the meeting. The liaison GP from the Division of General Practice attends the majority of meetings and is able to convey information about treatment planning to those GPs unable to attend the meeting.

Case study: involving GPs in a rural setting

Challenge

The patient's GP initiating a MDC meeting in a rural/regional setting.

Solution

To ensure the patient's GP is involved in the MDC planning, cancer care coordinators were introduced to a rural/regional health service to provide the link between GPs and other specialists in the care team. The patient's GP works closely with the patient's care team and can initiate a care planning meeting by contacting the lead clinician. The GP is encouraged to attend the meetings in person or participate via teleconference.

Outcome

Information presented by the GP about the patient's history and psychosocial issues at the MDC planning meeting has influenced decision-making around treatment and care planning.



