

The dream team: when will we make it a reality?

→ Anna Wagstaff

Multidisciplinary teams provide the best quality cancer care, as specialists come together to discuss diagnoses and plan treatments. They raise standards, improve patient experiences and save lives. Sadly, most of Europe's cancer patients never have the chance to feel their benefits.

For the 2.9 million people in Europe who will be diagnosed with cancer during the coming year, evidence-based guidelines will recommend a treatment programme that is likely to involve complex combinations of surgery, radiotherapy, systemic therapies and supportive care.

Getting that treatment programme right for each individual patient, with their own specific diagnosis and their own co-morbidities, needs and preferences, is beyond the powers of any individual practitioner. It needs a multidisciplinary approach to care, in which a team composed of all relevant medical and allied health disciplines work with one another and with the patient to diagnose, treat and manage the cancer.

But while the principle of multidisciplinary treatment is widely

accepted, the vast majority of these 2.9 million patients will never have their cases considered by a group of experts in a multidisciplinary meeting. Many treatments will be sub-optimal, patients will feel poorly supported and lives will be lost.

Traditionally, most cancers were primarily the domain of the surgeon. Though radiotherapy has been used to treat cancers for more than 110 years, and medical oncology has been used for the best part of the last century, these treatments were seen as alternatives or even as rivals.

It was in the early 1970s that the value of adjuvant chemotherapy in breast cancer became established. Gianni Bonadonna in Italy and Bernie Fisher in the US recall battles to convince the medical establishment (for which read "surgeons") of the value of routine chemotherapy following surgery for breast cancer.

They got their evidence through a meta-analysis of many trials, conducted by the Oxford Early Breast Cancer Collaborative Group, which marked the beginning of large-scale international cooperation on analysing clinical trials. This opened the way to the use of combinations of treatments in routine primary management and to generalise the multidisciplinary approach to other cancers, making possible many of the improvements over the last decades.

Breast cancer still leads the way, with a huge number of options combining surgical techniques with chemotherapy, hormone therapy and radiotherapy administered in various sequences. However, other cancers are rapidly catching up. So whether the cancer is in the lung or the liver, whether it is a glioma or a myosarcoma, the evidence shows – and the

guidelines stipulate – that the patient does best with careful selection of surgical, radiotherapy and systemic treatments.

Recent decades have also brought a cultural change towards a far more patient-centred approach to medicine in general, and cancer treatment in particular. More attention now tends to be paid to aspects of treatment such as control of pain, fatigue, nausea and other symptoms, and support in coping with the stress of a life-threatening disease, or in coming to terms with the potential loss of fertility or living with a stoma. Greater care tends to be taken to help the patient play a role in decisions to do with their treatment, which entails taking the time and effort to provide them

with understandable information, and to listen to them.

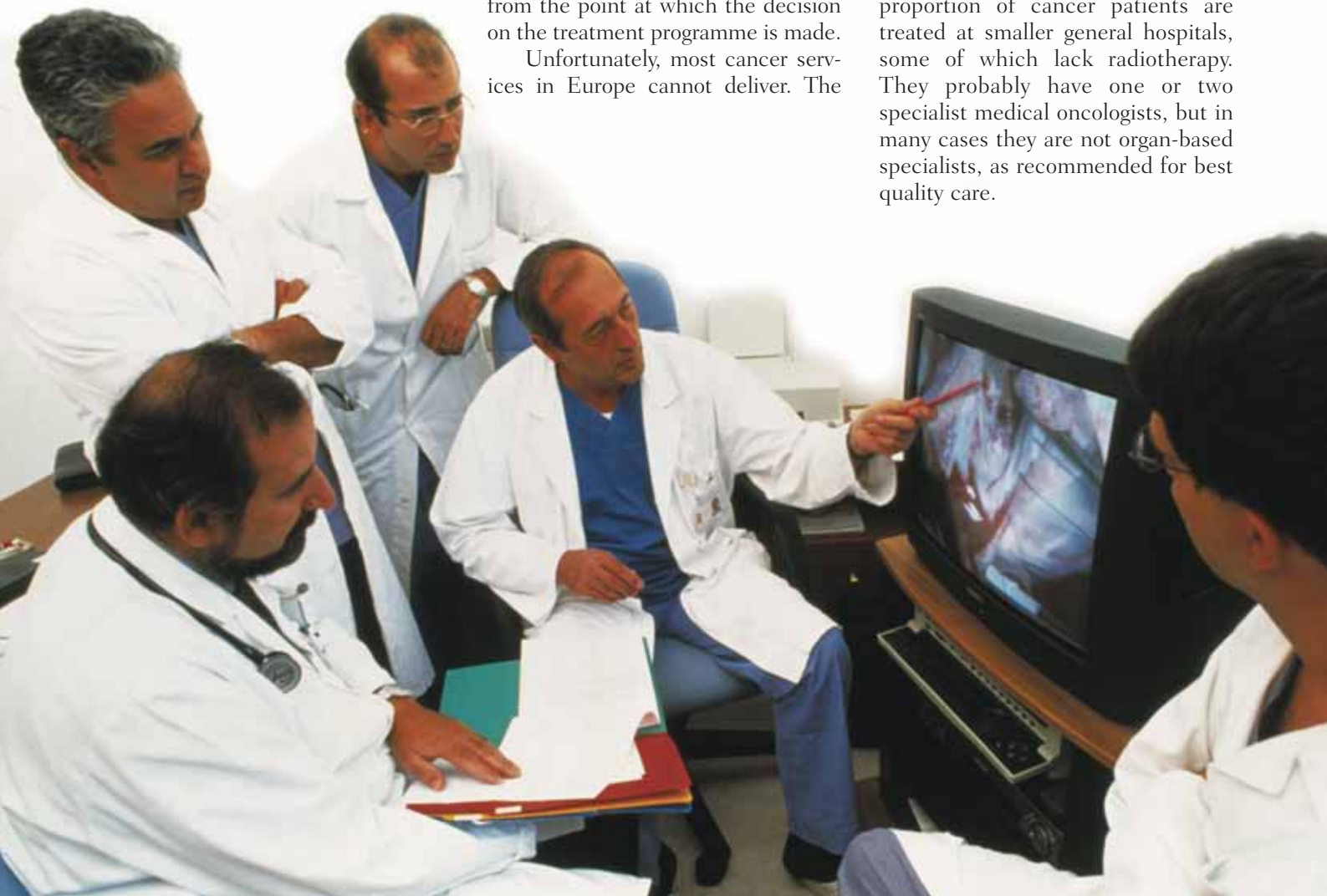
Branches of medicine dealing with these aspects of care, including psycho-oncology, and palliative care, have been steadily growing in most of Europe over past decades, and in some countries specialist cancer nurses have taken on an increasing role in areas such as symptom management and the provision of information. But there remains a major problem in integrating these aspects into the routine care of patients; many patients who could benefit are not being referred to the specialists who could help them. The multidisciplinary approach overcomes this problem by involving all specialists with a role to play in the patient's care from the point at which the decision on the treatment programme is made.

Unfortunately, most cancer services in Europe cannot deliver. The

centres of excellence, prestigious cancer institutes, major university hospitals that offer high-quality multidisciplinary care, are exceptions. The majority of Europe's patients are diagnosed and treated by specialists who have little training or practice in a multidisciplinary approach, and who work within structures that discourage or rule out multidisciplinary care.

Patients with breast or ovarian cancers may be treated at gynaecology clinics, where their doctor's primary training is in surgery, and where there are no specialist medical oncologists, radiation facilities or supportive care. In a similar way, many urology clinics routinely treat patients with prostate cancer.

In some countries, a large proportion of cancer patients are treated at smaller general hospitals, some of which lack radiotherapy. They probably have one or two specialist medical oncologists, but in many cases they are not organ-based specialists, as recommended for best quality care.



Even in large, well-staffed, institutions, patients are shunted from one department to the next, without ever having their cases considered by a gathering of specialist disciplines.

Leading practitioners say that things are moving in the right direction, but that change is slow and largely confined to more prestigious sites. It seems that only the UK and France have strategies in place to ensure that every cancer patient, no matter where treated, has his or her treatment planned and delivered by a multidisciplinary team (MDT). Both countries aim for 100% coverage within a few years.

THE DREAM TEAM

A multidisciplinary approach requires that new cases are discussed at the point of diagnosis, in a setting in which all specialists who have a role to play in diagnosis and care contribute towards a personalised, evidence-based care programme, taking into account the patient's co-morbidities and preferences.

Decisions should be efficiently recorded and communicated, so that professionals understand their roles while the patient understands the plan and is clear about who is responsible for what. Each step should be coordinated and monitored to ensure that information, scans etc. are passed on quickly and efficiently to the right people and that unnecessary delays are avoided.

Straightforward cases may be discussed only briefly. Complex cases may need to be reassessed by the multidisciplinary team to evaluate the patient's response to treatment, and to agree on the next step.

TEAM MEMBERS

The precise make-up of a multidisciplinary team varies according to the

cancer and the setting. In addition to surgeon, medical oncologist and radiation oncologist, the presence of histopathologist and radiologist is generally seen as essential, because management decisions depend on knowing details of tumour margins or location, or the exact proliferation index.

The inclusion of additional clinical staff may vary, case by case, according to the location of the cancer, or to the culture and tradition of the particular health service. In the UK, clinical nurse specialists are commonly included in multidisciplinary teams, whereas in France this is not the case. Teams treating gastrointestinal cancers may include gastroenterologists and specialist stoma nurses; teams treating breast cancer may involve reconstructive surgeons. Palliative care nurses and psycho-oncologists may be involved according to patient need.

The extent of specialisation within the team will also vary. Surgeons all over Europe are becoming increasingly specialised to a particular cancer, and often define the sub-specialisation of the team. Medical oncologists or radiation oncologists may be involved in a number of multidisciplinary teams dealing with two or more different types of cancers. Specialists who are thin on the ground have to spread themselves across multiple teams.

PATIENT SELECTION

Methods to select patients for discussion also vary. Bengt Glimelius, a medical and radiation oncologist who works as part of a colorectal cancer team in Uppsala University Hospital, Sweden, says that straightforward cases are simply treated according to protocol, and doctors only put a patient on the list for multidisciplinary

discussion if there are additional complications. "You can't discuss every single case; that would be impossible," he says, "unless you are at a teaching hospital, when the 'easier' and more common cases must also be discussed."

Mike Richards, the UK National Cancer Director, responsible for overseeing the national cancer plan, says, "My own preference would be to have every patient at least registered at the meeting. Some can be discussed in under a minute – 'This is a patient with a completely straightforward breast cancer. I've talked to her. She wants breast conserving therapy followed by x or y... Has anybody any concerns?' Everyone can say 'No that's fine' and you move on. But the nurse specialist may say, 'Are you aware that the patient's husband has Alzheimer's disease, and it will be very difficult for her to get to radiotherapy.' That doesn't take very long, but everyone in the team is then aware."

Christine Bara, director of the Department for Innovation and Improving the Quality of Care at the French National Cancer Institute, says that, under the national cancer plan, a similar practice is mandatory within the French system. "All cases are registered. Straightforward cases that require treatment with the standard evidence-based protocol are simply presented very fast. Only those who cannot be treated with a standard protocol are really discussed. A standardised form is completed for each patient, which is held by the cancer network."

VIRTUAL OR REAL?

Variations also exist in the extent to which the team is a physical entity at a single site, or is dispersed across departments in different wings of a



Michael Baumann, radiation oncologist and director of the Dresden Cancer Centre in Germany. The Centre was set up three years ago on the initiative of the surgeons and medical and radiation oncologists at the Dresden University Hospital, and provides an environment where they can work side by side. It has sparked great interest among other university hospitals, many of which have yet to adopt a multidisciplinary approach to treatment. Multidisciplinary working has come late to Germany; even in breast cancer the proportion of patients who have their treatment planned in a multidisciplinary team meeting is probably lower than 20%

hospital or even across two or more institutions. In the latter instance, members travel to meetings or hold videoconferences.

A good example of a single-site team is the cancer centre at the Carl Gustave Carus University Hospital in Dresden, Germany. This centre was set up three years ago on the initiative of the doctors from the hospital's surgical, medical and radiotherapy departments who had worked closely together for many years, but who wanted to establish multidisciplinary outpatient clinics.

Director Michael Baumann says that they felt that this ideal would only flourish in a physical centre. "I am not a big believer in virtual centres. Ours is a real centre. You can go there, there is a door and inside you

find medical oncologists, radiation oncologists and surgeons, sitting in neighbouring rooms."

Single-site arrangements also have clear advantages for patients, who have a single point of reference throughout all their stages of treatment. However, such arrangements may not be feasible outside cancer centres, university hospitals or centres of excellence.

It might be undesirable, as well as financially and logistically impossible, to restructure cancer services throughout Europe, so that every patient is treated by a specialist multidisciplinary team located at a single site, rather than at organ-specialist clinics or smaller general hospitals.

Individual practitioners and, by extension, multidisciplinary teams

need to treat a minimum number of patients each year to keep their skills up to scratch. This has been shown to be the case for surgeons, not only for difficult procedures such as pancreatic and oesophageal resections, but also for breast, colorectal and other cancers. There is growing evidence that this holds true for other disciplines.

Requiring multidisciplinary teams to operate from a single site while fulfilling minimum volume requirements would result in patients with less common cancers travelling enormous distances for treatment. This may be the best option for certain cancers or types of treatment, but other treatments can be carried out closer to home.

A 'virtual' team may be the best

“Ours is a real centre... there is a door, and inside you find medical and radiation oncologists and surgeons”



Jean-Pierre Gérard, director of the Antoine Lacassagne Cancer Centre in Nice, France. The Centre is one of the 20 cancer centres around which France's cancer services have been organised for decades, and has a long history of multidisciplinary working. Under the French Cancer Plan of 2003, all centres treating cancer, whether public or private, are required to work in a multidisciplinary way, if necessary by cooperating with one another. Around 50% of all French patients are currently treated in a multidisciplinary setting; the aim is to extend this to 95% of patients by the end of 2007

option – particularly if it is supported to overcome obstacles of distance and to function effectively. The alternative is that team members travel to locations closer to the patient. This can work across small distances, with doctors based at one site attending team meetings at another site once a week. However, there is already evidence from many countries that finding time to attend multidisciplinary meetings is putting pressure on hard-pressed team members. Adding in long journeys would exacerbate the situation.

Clearly, there is no single solution or blueprint. In both France and the UK, the emphasis has been on finding flexible, local solutions and allowing the system to evolve.

Bara, of the French National Cancer Institute, says, "These meet-

ings are necessary, but they do take time, and the geographical distribution of doctors can be a problem. What we are trying to do, jointly with the regional agencies and the cancer networks, is to concentrate these meetings in fewer locations in order to guarantee their medical representativity." Providing videoconferencing facilities and effective electronic communications systems is set to play a key role in this.

Jean-Pierre Gérard is director of the Antoine Lacassagne Cancer Centre in Nice, one of 20 cancer centres around which the new regional cancer networks are organised. He says the problem is particularly acute for radiation oncologists as there are no more than 500–600 in France, and their involvement is needed in the discussion of around

80% of cancer patients. "It is a question of time sharing and having videoconferencing, and also increasing the number of these specialists," he says.

BETWEEN THEORY AND PRACTICE

The logic of using MDTs to plan and deliver multidisciplinary treatment is irrefutable. However, recent studies looking at aspects of how teams function in the UK have revealed striking gaps between theory and practice.

One study (Macaskill et al, *Eur J Cancer*, in press), found that medical oncologists were absent for some of the time in over half of all breast meetings (55.9%). They did not attend at all in 41.2% of cases and attended for only some of the meeting in 14.7% of cases. Clinical oncologists (radiotherapists), by contrast,

More than half of the meetings take place over lunch time... many don't even provide lunch!

Richards identifies good leadership as one of two essential elements for effective team work

were present for the whole meeting in 70% of cases, and surgeons in 98.5% of cases.

One probable reason for this was that only a quarter (28%) of these meetings were held in 'protected time' set aside for the purpose. More than half of the meetings took place over lunch time, with a further quarter (26.5%) scheduled for breakfast time and 6.6% in the evenings.

Lesley Fallowfield, whose psycho-oncology team at Brighton and Sussex Medical School has been researching the functioning of MDTs, points out that many lunch time meetings don't even provide lunch! Breakfast and evening meetings can be particularly difficult for staff with childcare responsibilities. Another problem is that medical and clinical oncologists often have to cover a number of teams, often at different sites.

In the Macaskill study, respondents were asked to choose from a list of suggested improvements to the system. Top of the list (72.8% of respondents) was more time to attend meetings or for them to be held in a protected session.

Similar problems were highlighted in a review of breast cancer services carried out by the Clinical Standards Board in Scotland two years ago. Their report recommended that multidisciplinary meetings should be considered of equal importance to clinics and operating sessions, and should be included in individual job plans.

Finding a suitable venue can also

be a problem. Fallowfield recalls one team meeting in a room so small that some members were left standing in doorway straining to hear what was said or see what was shown.

Another team held meetings in a traditional lecture theatre with a top table facing tiered rows of seats. Predictably, she says, seats at the table with microphones were occupied by surgeon, radiologist and pathologist, while registrars and others sat in the first row of seats with breast specialist nursing staff relegated to the back. "Not only were the nurses rarely invited to contribute their opinion about patient care, but even had they wished to, they probably wouldn't have been heard. One recommendation we made was that the nurses should at least have a roving microphone."

The problem of unequal status must be tackled if every specialist discipline is to make its contribution. Fallowfield says, "Most people have been brought up in an educational system that makes it very difficult to get over hierarchical boundaries. Without training, it is very hard for people who have grown up in a world where they make a decision and everybody fits in around that, to operate in a way that will optimally benefit patients and also be helpful to the teams."

A recent study by her psycho-oncology research unit revealed that team members often have a poor awareness of the role their colleagues play in providing information to the patient. All the clinical nurses report-

ed that they regularly discussed physical, functional, social and emotional wellbeing with patients, yet few of their colleagues showed any awareness of this. Some issues were discussed with the patient by several team members, while others – such as clinical trials and family history – were recognised by only a few team members as their responsibility.

Even amongst medical specialists, working as a team and respecting and valuing everyone's contribution can be tricky. Baumann from the Dresden centre says, "One of the things that helps a lot is that the leadership structure is on a rotating system. At the moment I am director as a radiation oncologist, but it will rotate at some time to medical oncology or surgery or any other specialty in the cancer centre. It is not a radiotherapy structure, or a surgeons' structure, but something we carry together."

Mike Richards, the UK National Cancer Director, identifies 'good leadership' as one of two essential elements for effective team work (the other being administrative support). He recommends "an inclusive leader who will facilitate everybody to be part of the team and to make a contribution." He says that the last ten years have been about setting up MDTs, and the next five "should be about making those teams work effectively". Though he admits that much work needs to be done to work out how best to go about this, he mentions a two- to three-day training course that has been run for



In some European countries, oncology nurse specialists regularly discuss physical, functional, social and emotional wellbeing with patients. A multidisciplinary approach to treatment should ensure that this sort of support is included as an integral part of every patient's care plan

colorectal teams as an interesting example.

The course aimed to raise the technical skills of teams around the technique of meso-rectal excision, but Richards says it has proved to have a very helpful spin-off in bringing teams together. It offered teams the opportunity to exchange ideas about how they worked, which is something they would never usually do.

"I went to one of the courses, and talked to the team. The surgeon said, 'Now I really know how to do the procedure properly. I thought I did before I went.' The radiologist said,

'Now I understand why they want the MRI scan done in a particular way.' The pathologist said, 'Now I understand why they want me to report the circumferential margins in a particular way.' The nurse specialist said, 'Now I understand how to explain this operation to a patient.' And they all said, 'It has been valuable time working together and we feel we all know each other better and we will work together better.' We are beginning to get feedback that teams are doing things differently, so we are seeing an evolution.

"We never said people had to go

on the CRC programme, but word of mouth has been very effective. Once you get the first ten teams saying, 'That was very helpful,' then others say, 'Actually we want to do the same.' We reckon that within the next few months almost all of the 186 CRC teams in England will have been on that course."

Richards believes this example could be followed for other cancers. "I'm sufficiently impressed that I would like to encourage it for other disease areas."

OILING THE MACHINE

Another crucial area showing serious gaps between theory and practice has to do with the quality and completeness of information, and procedures for recording decisions and ensuring they are implemented.

A review of decisions taken by an upper gastrointestinal multidisciplinary team published earlier this year (*Ann Oncol* 17:457–460) found that in just over 15% of the cases, decisions were not implemented. The most common reason was that information on the patient's co-morbidity had not been available or had been given insufficient consideration during the meeting. The report recommended that methods be standardised to ensure the inclusion of co-morbidity data in MDT meetings.

The other main reason for decisions not being implemented was patient preference. This raises complex issues. Is it feasible to find out about patient preferences before a multidisciplinary team meeting con-

The problem of unequal status must be tackled if every specialist discipline is to make its contribution

Extra resources for administrative staff will be key to encouraging a multidisciplinary approach

siders the options? The report gave an open verdict, saying simply that the matter warrants further research.

Fallowfield identifies a problem in ensuring that every member of the team is aware of decisions, and that patients receive a consistent message. During an MDT training session, a rectal cancer patient listened with dismay as a nurse explained colostomies – what they look like, how the patient should care for them. The patient had been told that there was no need for a colostomy, because the MDT decided that sphincter-saving surgery would be safe, but the nurse had not been present at that meeting.

MDTs must be well enough resourced to ensure that every meeting has access to a full set of information (patient files, scans and other diagnostic results), that every team member knows which patients are due to be discussed and where and when meetings are held, and that decisions are recorded and communicated effectively.

Getting the administrative side right was the second element identified by Richards as vital for teams to work effectively. His view is endorsed by others in different countries and different settings. Asked what single measure would most improve the effectiveness of MDTs, Bengt Glimelius, clinical oncologist in the colorectal team at Uppsala, Sweden, says, “To have more time and not to have to do all those extra administrative tasks that fall on you. We need more admin support.”

In Dresden, Baumann believes that funding for infrastructure was essential in making multidisciplinary care a reality. Without it, he says that management of patients would have continued to be driven by separate departments. His hospital struggled to find funds from existing departmental budgets. Baumann argues that allocating extra resources for the essential administrative staff is the single most useful thing authorities can do to encourage hospitals to move towards multidisciplinary care.

In France, the state allocates funding to all hospitals, clinics and cancer centres where cancer patients are treated, whether they are in the public or private sector. Funding is specifically for the establishment of cancer coordinating committees – ‘the 3 Cs’ – whose role is to support the delivery of care through specialist multidisciplinary teams, which is being made mandatory under the French national cancer plan.

Cancer coordinating committees are responsible not only for organising multidisciplinary meetings, recording decisions, and computerising patient information, but also for auditing their effectiveness through systematic reporting of a range of activity and quality indicators, including patient outcomes.

In the UK, cancer services were already being provided within a single infrastructure – the National Health Service. The cancer plan required that infrastructure to be reorganised.

Richards says that the nature of administrative support for MDTs is

decided at local level. “Some hospitals advertise for a separate post, while others may allocate the task of servicing MDTs to one of the nursing staff. Depending on the size of the team and the throughput of patients, you might be able to have a coordinator who covers more than one MDT. Alternatively, the person who coordinates team meetings might also navigate or track patients through the system, knowing where the patients are and what is going on, and making sure the CT scan comes back and is acted on, and the next appointment is made and so on.”

Many teams function well, but Fallowfield has come across teams with no additional support that are struggling. The Macaskill study into breast teams found that almost 6% of MTD decisions were not recorded in patient notes or on a special form. The study says that this raises questions about whether the decision is truly available for patients and staff members who were not at the meeting. “It also raises the question of the relevance of the decisions made at the MDM where they are not recorded.”

NO TURNING BACK

While some studies have revealed improvements from multidisciplinary working – including better diagnostic practice, closer compliance with guidelines, a more consistent provision of psychosocial support, a stronger input from nurses, and improved care co-ordination – it places heavy pressure on team members’ time and as yet



Bengt Glimelius, medical and radiation oncologist in the colorectal cancer team at Uppsala University Hospital in Sweden. Glimelius has conducted patient consultations jointly with the colorectal surgeon for the past 25 years. More recently a radiologist and often a pathologist have also been present. Though a large proportion of breast cancer patients are now treated in a multidisciplinary setting in Sweden, the figure for colorectal cancers is closer to 40%, while for prostate, lung or gastric cancers, it is more like 10-20%. Multidisciplinary teams are likely to be included in new quality indicators currently being drawn up for Sweden's hospitals

there is little robust evidence to show that it improves clinical outcomes. However, ask any of the practitioners in the UK or France who have been obliged to start working in this way and, despite grumblings and misgivings, the principle is no longer in question and there is no mood to return to old ways.

"I say at virtually every talk I give, that I believe the most important step we have taken in the last 10 years is to move to MDT working, and I never get anyone saying – Mike you are wrong about that," says Richards. "I can assure you they can be vocal about things that they don't like. For a lot of people, it is a source of job satisfaction because you get a lot of peer support from your group and you know you are doing the best you can for the patient."

In France, moves to extend MDTs to cover all cancer patients started three years ago, and already they are reporting around 50% coverage, with the aim of reaching 100% by the end of 2007. Given the diverse

nature of the institutions that have to work together – not least the mix of private and public – some level of friction was to be expected. However, Bara of the National Cancer Institute says the principle is now completely accepted, and emphasises the role of the regional networks in this success. "Everybody is saying the same thing. 'Multidisciplinary meetings are necessary and have a huge educational value.' Any resistance now only comes from isolated persons. Doctors working in cancer today say they can no longer imagine working without recourse to multidisciplinary."

Patients also appear to be giving the system the thumbs up. The Dresden Cancer Centre conducts systematic audits of patients, and Baumann says the feedback has been very positive. "They understand that we need specialists. We don't want generalists who think they can do everything. And they understand that for this reason they have to move to different places – to go for surgery to a surgeon and for radiotherapy to the

RT department. But they like to have this cancer centre as a joint structure that they can always go back to – they know their whole treatment is steered by this structure."

Surveys conducted in the UK in 2000 and 2004 show patient satisfaction increasing by 4 to 16 percentage points on issues ranging from, "Given written information at diagnosis" (from 45% to 61%), to communication "Given completely understandable explanations about side-effects" (from 63% to 76%), symptom control "Felt everything had been done to relieve pain" (from 81% to 85%) and general issues "Always treated with respect and dignity" (from 79% to 87%). Richards believes that the MDT approach is responsible for a large part of this improvement.

Multidisciplinary meetings also raise the overall quality of cancer services, not just in individual cases. In effect they offer continual peer review, making it easier to detect and correct practitioners who consistently stray from best evidence-based

practice. They provide a superb setting for specialists to learn more about the contribution of other disciplines in the care of their patients, and for younger practitioners to learn from more experienced hands.

Glimelius says, "It takes time to have 10 or 20 people sitting there. You listen to ten cases, and are involved directly in maybe only two. But listening to the others, and understanding why a decision was made in one direction or other, helps your future patients. I'm not sure how a health economics study could put a value on that."

Jean-Pierre Gérard does venture to put a figure on the impact on patient outcome. "It is usually said that if the best treatment was applied to all patients, we would improve the cure rate by between 5% and 10%. In France we have 150,000 deaths from cancer every year, which would be reduced by up to 15,000 if everybody got the best treatment. I think half of this will be gained by MDTs."

This, he says, will mainly come about through raising standards in smaller establishments – public and private – closer to the standards found in academic institutes.

THE CARROT OR THE STICK?

Sadly, the consensus on the principle of MDTs among those who already work in this way will not benefit most of the 2.9 million Europeans who will be diagnosed with cancer in the coming year. They need the principle to be put into practice in every location.

Richards says that he does not

believe it would be possible to extend MDTs to all treatment centres in the UK without some form of national cancer plan. Bara agrees. The French cancer plan has driven change, provided the policies and the finance to implement them and supported pilot schemes to get them right. "That's how it has been possible to move so quickly, and I think that in 2007, MDTs will be one of the measures [of the national cancer plan] we will achieve successfully."

But what works in one country may not in another. A working group in Australia has offered a useful contribution to this debate. Rather than map out any particular organisational solution, they have drawn up a set of "Principles of multidisciplinary care," (see Zorbas et al, *Med J Aust* 179:528–531), which "aim to accommodate a variety of delivery models and to enable clinicians to apply them according to the geographical, social and cultural context in which they work." The principles emphasise the importance of the team approach, good communication, access to the full range of therapies, maintaining standards of care, and involving the patient in decision-making.

Australia is a country of vast distances, where the closest specialist radiation oncology services for breast cancer patients living in the city of Darwin, for instance, are located 3,000 kilometres away, in Adelaide. If Australia can map out how to organise a national network of specialist MDTs, surely there is little excuse for failure in any European country.

That is not to say that this is an easy process. Former central and eastern European health systems may have unified structures in common with the UK National Health Service, but many have an acute shortage of pathologists, medical oncologists or radiation oncologists, constraining moves towards MDT working.

Other European countries have no such single unified healthcare provider. The French national cancer plan is interesting because it encompasses public and private provision within a single network. The MDTs at the Antoine Lacassagne Centre are open to private clinics within the onc-Azur regional cancer network, says Gérard, and some private doctors do attend. Conversely, in Cannes, public hospitals work with private radiotherapy clinics, because they have no facilities of their own.

But while this public–private mix is typical of many European health systems, not all of them have France's tradition of a strong central state. In Germany, responsibility for health is devolved to a regional level and doctors retain a high level of autonomy over how they organise their work. Baumann believes they need the carrot rather than the stick. He accepts that Germany has been slow to take on board MDTs, and that even among university hospitals, many are still not working in the new way. But he says there is a great interest in what they have done in Dresden, and the most helpful thing would be for resources to be allocated to support the change.

There is a need to inject a sense of urgency among those who can influence Europe's cancer services

MEP Karin Jöns is a breast cancer survivor and the German representative for the European Breast Cancer Coalition advocacy group, Europa Donna. She says the German health-care system is very fragmented and there are few levers for effecting change, no matter how strong the evidence base. Health policy is organised in a federal way and is in the hands of the 16 regional governments (Länder), but it is the doctors, together with the health insurances (there are no fewer than 55 of them), who hold the real power.

She believes that, for Germany and other public healthcare systems, the way forward lies in a system of reliable accreditation and re-accreditation for specialist units that offer diagnosis and treatment that comply with specified quality criteria. Patients would then be able to make an informed choice about where to go for the best quality treatment, and hospitals and clinics would have an incentive to raise their quality of care.

This approach has been pioneered by the European Society of Mastology (EUSOMA), which wants to see all Europe's breast cancer patients treated by multidisciplinary teams of breast specialists within accredited breast units fulfilling strict criteria on staffing of the medical team, treatment procedures and minimum case loads.

Jöns played a key role in getting many of these criteria – particularly the multidisciplinary approach – adopted by the European Parliament as part of the European Breast Cancer Resolution in 2003. Since then, she has been campaigning to get the recommendations implemented throughout Europe, focusing particularly on her own country, but she is not satisfied with the pace of change.

Though the German Cancer Society accredits breast units, it has adopted quality criteria that are far less stringent than both the EUSOMA and the EU guidelines. Jöns says that hospitals are pooling patient numbers to show they treat a minimum of 150 new cases a year, even though they are not working together as an integrated breast unit. Many so-called breast units, she says, have no in-house pathologists, and have to get the pathology done at another hospital, and are therefore unable to control the quality. Most don't have breast nurses – or even know what a breast nurse should be. And while the EU guidelines call for multidisciplinary team discussions pre- and post-treatment in 100% of cases, certification is being handed out in Germany to hospitals that can show 20% of patient cases are considered at some point by an MDT, so long as the hospitals give assurances they are moving towards 40%.

Jöns believes this provides window dressing without a commitment to real change. "Most hospitals want to get certified as a breast unit so that they get a better image. But often they do not work in a serious multidisciplinary way. Some doctors still believe they know everything and can do as they please without reference to any guidelines. They say 'We've always done it in this way, and in our country everything is OK.'"

That everything is far from OK is evidenced by a report into breast cancer operations compiled by the Bundesgeschäftsstelle Qualitätssicherung. It found that in 622 of a sample of 691 hospitals, surgical 'security' margins were smaller than evidence-based guidelines. Jöns believes that this is largely a diagnostic failure. "In 50% of cases of breast

cancer they only realise during surgery that it is cancer. If they had done it in a multidisciplinary way and had known the diagnosis in advance, then the surgery would have been done in the right way. Unfortunately this is not the only problem with breast surgery."

Such monitoring can play an important role in combating complacency and convincing the medical establishment of the need for change. The Swedish government is also developing quality indicators which county councils will be obliged to monitor. Glimelius expects MDTs to feature. "It won't be a law, but there will be the chance to check whether or not it has happened."

Current and future cancer patients across Europe hope that a combination of national cancer plans and accreditation backed by EU guidelines and recommendations will deliver top-quality multidisciplinary care. But how long will it take?

Jöns points out the EU adopted guidelines on breast cancer screening 15 years ago, but this service will not be available throughout Germany until the end of 2007. Women in many other EU countries will have to wait even longer.

There is a need to inject a sense of urgency among those who have an influence over the shape Europe's cancer services – the sense of urgency that convinced Jacques Chirac and Tony Blair to put some political clout behind their countries' respective cancer plans.

Currently 1.7 million European citizens die from cancer each year. If Gérard at the Antoine Lacassagne Cancer Centre is right in estimating that MDT working could increase the cure rate by 2.5%–5%, that alone could save as many as 85,000 lives a year. As Gérard himself put it, "Not bad eh?"