

The 6-year attendance of a multidisciplinary prostate cancer clinic in Italy: incidence of management changes

Tiziana Magnani*, Riccardo Valdagni*[†], Roberto Salvioni[‡], Sergio Villa[†], Lara Bellardita[§], Simona Donegani[§], Nicola Nicolai[‡], Giuseppe Procopio[¶], Nice Bedini[†], Tiziana Rancati* and Nadia Zaffaroni^{††}

*Prostate Cancer Programme, Scientific Director's Office, [†]Division of Radiation Oncology 1, [‡]Division of Urology,

[§]Prostate Cancer Program, Psychology Service, [¶]Division of Medical Oncology 2, ^{††}Division of Molecular Pharmacology, Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy

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OBJECTIVES

- To describe the establishing of a multidisciplinary clinic for men with prostate cancer at the Istituto Nazionale Tumori, Milan.
- To evaluate the quality of care provided and to describe the management changes implemented to improve standards and meet new needs.

MATERIALS AND METHODS

- In March 2005, we established a multidisciplinary clinic comprising weekly clinics and case-discussion sessions.
- We have altered the organisational model periodically to meet new needs and improve quality.

RESULTS

- We held 2260 multidisciplinary clinics up to March 2011.
- For stage distribution, patients with low-risk prostate cancer increased to a peak of 61% in 2009, probably because of the anticipation of diagnosis and the active surveillance expertise of the Prostate Cancer Programme at Istituto Nazionale Tumori, Milan. The slight decrease in 2010 might be due to the availability of

What's known on the subject? and What does the study add?

The benefits of the multidisciplinary approach in oncology are widely recognised. In particular, managing patients with prostate cancer within a multidisciplinary and multiprofessional context is of paramount importance, to address the complexity of a disease where patients may be offered multiple therapeutic and observational options handled by different specialists and having severe therapy-induced side-effects.

The present study describes the establishing of a multidisciplinary clinic at the Prostate Cancer Programme of Milan Istituto Nazionale dei Tumori, its effects on the quality of care provided, and strategies implemented to meet upcoming needs and improve quality standards. Having analysed the data of the 2260 multidisciplinary clinics held from March 2005 to March 2011, our dynamic and modifiable organisational model was evaluated for ways to optimise the human resources, offer high-quality standards, meet new needs and ultimately reduce costs. The study is focused on the organisational aspects and adds a perspective from one of the major oncological centres of reference in Italy and in Europe.

robot-assisted prostatectomy in several hospitals in Milan, and the start of a multicentre active surveillance protocol in December 2009.

- In terms of the efficacy of our multidisciplinary strategy, 11% of drug therapies (mostly hormones) prescribed outside our institute were terminated in the multidisciplinary clinic, and 6% of indications formulated in the multidisciplinary clinics were altered during the case-discussion sessions.

CONCLUSIONS

- The multidisciplinary approach needs to be adaptable to meet new needs and improve quality.

- Our experience has proved successful for both physicians and patients. The team agrees on strategies; complex cases are managed by a multidisciplinary team; dedicated psychologists contribute their knowledge and perspectives; and patients report the feeling of being cared for.

KEYWORDS

prostate cancer, multidisciplinary communication, patient-care team, interdisciplinary health team, patient-centred care, organisational structure

INTRODUCTION

Prostate cancer is the most frequent cancer in men living in industrialised countries and one of the most complex diseases encountered by the oncology community [1,2]. The incidence of prostate cancer in Italy is one of the lowest in the European Union: according to a research study by the Epidemiology Unit of Istituto Nazionale Tumori, Milan, and the Istituto Superiore di Sanità, Rome, there were 43 000 incident cases, 9200 deaths, and 174 000 prevalent cases in Italy in 2005 [3]. Diagnoses increased dramatically in the early 1990s when the extensive use of PSA as a biomarker began, leading to the overtreatment of slowly progressing and potentially indolent tumours that would otherwise have remained clinically undetected during the patient's life [4–6].

Depending on the state of their disease, there are several therapeutic options for patients with prostate cancer: open, laparoscopic, or robot-assisted laparoscopic prostatectomy; conformal, intensity-modulated, or image-guided external radiotherapy; low-dose-rate or high-dose-rate brachytherapy; hormonal therapy alone or combined with radical therapies; chemotherapy; observational strategies (active surveillance and watchful waiting); or experimental therapies, e.g. cryotherapy and high-intensity focused ultrasound [7–10]. There are no clear differences among the available radical therapeutic approaches (surgery, external radiotherapy, brachytherapy) for cancer control rates in disease of the same state [7–12]. Conversely, therapy-induced adverse effects potentially affect the patient's health-related quality of life and must be evaluated carefully [13–15]. Ideally, patients with prostate cancer should be informed about the pros and cons of their options, the therapy-induced adverse effects, and the available rehabilitation programmes, thus becoming active participants in the decision-making process [16,17]. Realistically, patients often receive partial, contradictory information from the specialists they contact, thus experiencing decision-making as a difficult and stressful process [18–20]. This scenario is complicated by new and highly sophisticated technologies and therapies and the amount of information available in the press and on the internet, combined with the consumers' demand for the 'best treatment' available

and their inability to distinguish between evidence-based medicine and marketing strategies [21]. Patients with prostate cancer should be comprehensively informed about the disease, the therapeutic and observational strategies available, the therapy-induced adverse effects, and the rehabilitation programmes, and should be accompanied in the decision-making process [18]. To address the complexity of prostate cancer, the Prostate Cancer Programme at Istituto Nazionale Tumori, Milan, decided to change from a mono-disciplinary setting to a person-focused multidisciplinary clinic in March 2005.

The present article describes the establishing of our multidisciplinary clinic, its effects on the quality of care provided, and strategies implemented to meet upcoming needs and improve quality standards.

MATERIALS AND METHODS

The Prostate Cancer Programme at the Istituto Nazionale Tumori, Milan, was established in September 2004. Its aims were to outline and implement research strategies; to reorganise on-going clinical and experimental studies; to move from mono-specialist management to multidisciplinary management; and to optimise the human and technological resources within a disease-focused translational framework.

For clinical practice, the priorities were the re-organisation of the professionals already working with patients with prostate cancer; the constitution of a multi-professional and multidisciplinary team; the identification of shared goals and objectives within the team; and the preparation of institutional diagnostic, therapeutic, and observational guidelines. This last task was directed towards creating a shared working methodology and language with which to address patients with prostate cancer in all states and stages.

Several articles have reported the value of a multidisciplinary approach in dealing with the complexity of oncological malignancies [22–27] and prostate cancer in particular [28–36]. To address this issue, in March 2005, the Prostate Cancer Programme commenced a multidisciplinary clinic comprising two complementary phases:

1. *The clinic*

On Fridays from 0800 h to 1300 h, a urologist, a radiation oncologist, a medical oncologist, and a psychologist meet and simultaneously examine 10 patients with prostate cancer (new diagnoses; untreated patients; and treated patients looking for a consultation). Supportive care, rehabilitation, and specialist palliative care interventions are available on demand. The medical history is recorded, a DRE is performed, co-morbidities are considered, and possible therapeutic, observational, and follow-up strategies or research protocols are proposed. A written report is prepared for the patient's GP. The patients and their significant others are offered psychological support (decision-making support, counselling for individuals, couples, and families, and self-help groups).

2. *The multidisciplinary case discussion*

On Mondays from 1300 h to 1500 h, cases examined in the multidisciplinary clinic, patients on active surveillance and watchful waiting who came for a follow-up, and cases examined with a mono-disciplinary approach that are considered particularly problematic or complex, are discussed in this continuing medical education activity open to the professionals participating in the Prostate Cancer Programme (urologists, radiation oncologists, medical oncologists, psychologists, uropathologists, radiologists, experimental researchers). The discussions aim to share the decisions formulated in the clinic, to tailor therapeutic or observational strategies, to evaluate the adherence to guidelines, and to check quality assurance. The presentation and discussion of each case is recorded on the patient's chart. If any change is made to the indications formulated in the clinic, the written report for the GP is modified and the patient is informed accordingly. Patient data are then entered into a web-based electronic medical record.

In the first 3 months of activity, multidisciplinary clinics were held by the senior specialist members. After the set-up phase, new staff members joined the core team, which is currently composed of the Prostate Cancer Programme Director, six part-time urologists, two full-time and one half-time radiation oncologists, three part-time medical oncologists, two full-time

FIG. 1. Risk class distribution per year since 2006.

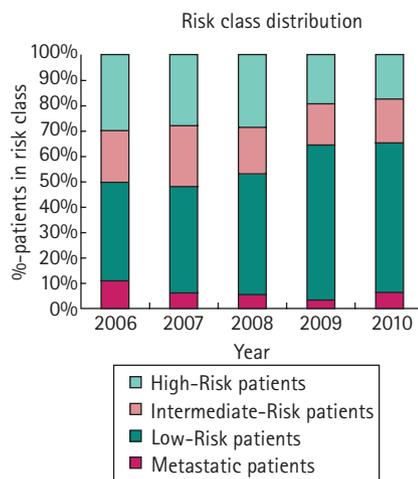
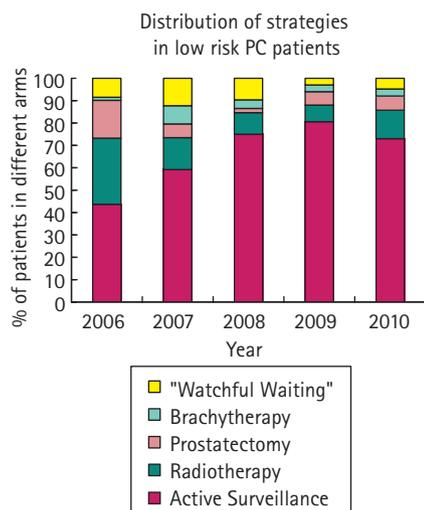


FIG. 2. Percentage of patients with prostate cancer in the low-risk group referred to our multidisciplinary clinic who were offered radical prostatectomy, radiotherapy, brachytherapy, or active surveillance, and who chose active surveillance.



and two part-time psychologists, one part-time expert in supportive care in cancer, two part-time palliative care experts, one research fellow specialising in radiation oncology, and three research fellows specialising in psychology. The non-core team includes one full-time project manager, one full-time secretary, one part-time data entry clerk, one part-time data manager, two part-time uropathologists, one part-time immunologist, and several ancillary workers

involved in laboratory testing and radiology (conventional radiology, MRI, CT, ultrasonography, and nuclear medicine).

To date, our model system has been offered to patients with prostate cancer in all states of the disease who may also access palliative and supportive care and rehabilitation services, with a comprehensive programme including an outpatient symptom-control clinic, a day-hospital, rehabilitation of treatment-related complications, a hospice and home-care.

Before the multidisciplinary clinics started, personnel at the central Physician Referral Service, who are responsible for making new and follow-up appointments for all specialties and patients, were provided with guidelines about how to interview patients, determine their diagnosis, and, in cases of prostate cancer, transfer them from specialty-oriented requests (mono-specialist consultations with a urologist, radiation oncologist, or medical oncologist) to the multidisciplinary clinic.

Since its implementation, our organisational model has been characterised by a high level of dynamism and flexibility, and has been modified to improve standards and to deal with organisational problems. Since 2006, a steering committee composed of the Prostate Programme Director, the project manager, the senior urologist, the senior radiation oncologist, the senior medical oncologist, and the senior psychologist has dealt with organisational and relational problems within the multidisciplinary team and has approved any proposed changes in the workflow.

With the increase in the number of patients with prostate cancer opting for observational strategies, specifically active surveillance, a multidisciplinary follow-up clinic run by a urologist and a radiation oncologist (psychologist on demand) was organised on Friday afternoons in 2006 (eight patients) and on Tuesday afternoons in March 2011 (six patients). These cases were included in the multidisciplinary case discussions.

In 2007, a patient-dedicated secretary joined the Prostate Cancer Programme as contact person for patients and specialists. She confirmed appointments with patients to reduce missed appointments; this is now

done by a nurse specialist. The secretary makes follow-up telephone calls to patients who are taking time to make decisions.

Since 2009, the quality of the information the patients receive in the multidisciplinary clinics and follow-up clinics has been routinely assessed during case discussions. Since 2009, we have recorded the reason for referral to our multidisciplinary clinic, whether the patients have already received therapeutic or observational indications from other specialists, and whether those indications differ from our guidelines.

Following the model successfully implemented by the Kimmel Cancer Center at Thomas Jefferson University, Philadelphia, PA, USA [30], a prostate cancer nurse specialist has been coordinator of the multidisciplinary clinic since September 2010, interviewing the patients scheduled for the clinic 1 week before their appointment, discussing the data collected with a clinician, and reorganising the list if necessary.

RESULTS

From March 2005 to March 2011, we held 2260 multidisciplinary clinics. Figure 1 reports the disease distribution per year for the period 2006–2010. Most of the patients with prostate cancer referred to our multidisciplinary clinic were staged in the low-risk group and that number increased from 40% in 2006 to 61% in 2009. There are two main explanations for this: (i) opportunistic screening with PSA generally leads to anticipation of the diagnosis; and (ii) the Prostate Cancer Programme is known nationwide to promote active surveillance as an alternative to radical treatment within a research protocol. Figure 2 presents the percentage of patients with prostate cancer in the low-risk group who were offered radical prostatectomy, radiotherapy, brachytherapy, or active surveillance, and who chose active surveillance. From the 44% recorded in 2006 this figure jumped to 81% in 2009. Although anecdotal, this suggests that increasingly well-informed patients were referred to our multidisciplinary clinic specifically for our active surveillance study.

We have two hypotheses to explain the slight decrease in patient numbers in 2010:

(i) robot-assisted prostatectomy has become routine in several hospitals in Milan; and (ii) the multicentre prospective active surveillance protocol SIUR0 PRIAS ITA, coordinated by the Prostate Cancer Programme with 10 participating centres, began in December 2009.

We analysed our data between March 2005 and December 2010 to assess our success at applying a dynamic, adaptable, and therefore modifiable organisational model to optimise the human resources available, individualising the diagnostic and therapeutic procedures, offering high-quality standards, and ultimately reducing costs. Because 12% of patients arrived with incomplete data, we introduced a nurse specialist as a coordinator in September 2010; this nurse has been highly effective in optimising the clinics by: (i) organising the list according to the state of the disease, thus optimising the presence of the professionals (urologist, radiation oncologist, and psychologist for low-, intermediate-, and high-risk patients with prostate cancer; the same team plus the medical oncologist for patients with castration-resistant or metastatic prostate cancer), (ii) re-scheduling patients with incomplete data; (iii) identifying patients who need palliative or supportive care; and (iv) following-up on patients who were prescribed staging in the first multidisciplinary clinic or who took time to make a decision.

In terms of the efficacy of the multidisciplinary strategy, (i) the frequency of drug therapies (mostly hormones) prescribed by physicians working outside our institute that were later considered inappropriate and terminated in the multidisciplinary clinic was 11%; and (ii) the frequency of indications formulated in the multidisciplinary clinics that were later changed during the case discussions, after checking adherence to our institutional guidelines, was 6%; this latter figure stresses the importance of the interdisciplinary discussions, which form a measure of quality control.

To evaluate overall patient satisfaction, the patients are periodically asked to complete a 10-item satisfaction questionnaire, covering: (i) Physician Referral Service; (ii) waiting time; (iii) registration and payment; (iv) accessibility, comfort, and cleanliness of the rooms; (v) observance of scheduling; (vi)

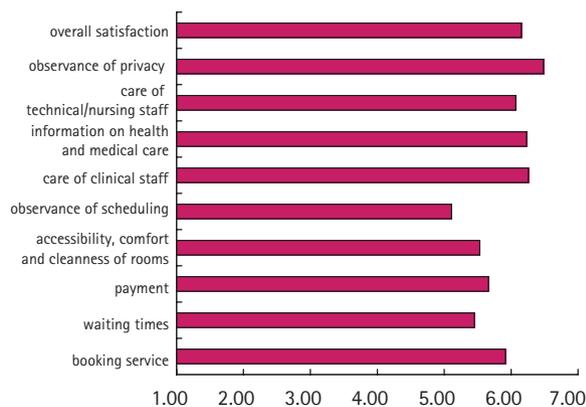


FIG. 3. Summary results of satisfaction questionnaire (mean values of answers for each item; 1 indicates 'very poor quality' while 7 indicates 'very high quality').

care by the clinical staff; (vii) information given on health and medical care; (viii) care by the technical/nursing staff; (ix) observance of privacy; and (x) overall satisfaction. For each item, seven ratings are possible, from 1 (very poor) to 7 (very high). In 2010, the mean scores were between 5.11 (for observance of scheduling) and 6.48 (for observance of privacy). Figure 3 shows the mean values for each item.

DISCUSSION

In our multidisciplinary clinic, different specialists interact both in the clinic and in the case-discussion sessions. This might appear time-consuming and costly for the Italian NHS reimbursement system. It is a fact though, that before they make any treatment decision, patients with prostate cancer have a right to clear, adequate, and complete information about the different therapeutic and observational strategies, therapy-induced adverse effects, rehabilitation programmes available, and the estimated outcomes and risks of failure, based on the state of their disease. Increasing numbers of patients autonomously contact different specialists, collect information, and then make their own decisions [18]. Beside the risk of collecting conflicting and confounding information, this opportunistic approach generally increases the number of mono-specialist clinics a patient attends, and, at least in our health system, increases the cost of reimbursement.

Our multidisciplinary clinic offers patients the opportunity to have all the specialists involved in prostate cancer care in the same

room at the same time. To cover the costs of several different physicians treating the same patient simultaneously, the Italian NHS acknowledges the multidisciplinary effort and reimburses multidisciplinary clinics at a higher rate than that for mono-specialist clinics.

In our experience, the multidisciplinary approach to prostate cancer has been successful in dealing with the complexity of this disease. Patients receive adequate information on the therapies and observational strategies available from specific physicians and generally report a positive feeling of being cared for by a team of both medical and administrative personnel.

The multidisciplinary team acts objectively to propose possible treatments and observational strategies, agrees on indications, benefits from the inter- and multidisciplinary management of complex cases, and shares responsibility for critical issues like co-morbidity or exclusion from research protocols. The multidisciplinary team also takes advantage of the presence of psychologists, who add their knowledge to the evidence-based specialist approach, thus ensuring that the patients' mental well-being is catered for in addition to their physical needs. Our multidisciplinary approach brings a challenging dynamism to the patient-doctor relationship [37] and also to the doctor-doctor relationship, and allows the continual improvement of multi-specialist knowledge.

However, it is essential to stress that the simultaneous presence of different specialists in the same room is by no means

a guarantee of success. We think that the clinical case-discussion sessions are very important. Specialists have learned to evaluate different options, accept other specialists' points of view, and benefit from the psychologists' different perspectives. Because all therapeutic and observational proposals must be approved by the team, all the options are considered objectively, thus avoiding the promotion of one particular therapy and ensuring the regular presentation of observational strategies, e.g. watchful waiting and active surveillance. Multidisciplinary teamwork improves the case management of individual patients. Discussing the patient's best options, evaluating him holistically, checking possible research trials suitable for his disease state, and taking his values and priorities into consideration, means that evidence-based medicine is tailored to that patient, thus avoiding unnecessary examinations and therapies and creating good patient-specialist and specialist-specialist relationships.

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CONFLICT OF INTEREST

None declared.

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Correspondence: Tiziana Magnani, Prostate Cancer Program, Scientific Director's Office, Fondazione IRCCS Istituto Nazionale dei Tumori, Via Venezian 1, 20133 Milan, Italy. e-mail: Tiziana.magnani@istitutotumori.mi.it