

of circulating tumor cells/DNA, and at lower or higher risk to develop metastases. Furthermore, several tumors are locally advanced and either resectable only with loss of function like in the gastrointestinal region, trunk or extremities, or unresectable. Furthermore, several tumors have measurable metastases; however, sometimes associated with a biology allowing long term survival after surgical excision. Local treatment by surgery, radiation or both is the best option for the primary tumor; however, inadequate to have impact on micro- or macrometastases and therefore on survival. Combined modality approach follows this systemic character of obviously localised solid tumors, or the need to enable better surgery with loss of function. Several trials have shown that in many tumor types combined modality is the treatment of choice, and should substitute the traditional approach with primary surgical treatment and – probably – postoperative decision on the treatment of residual micro- or macroscopic mass or potential macrometastases by "adjuvant" measures. The complexity of this multidisciplinary approach requires a high expertise of the treating oncologists whatever nature (surgical or medical oncology based) to decide the optimal treatment strategy and perform the best treatment modality with the optimal and necessary expertise. Multidisciplinary teams are necessary to define the optimal treatment strategy and – sequence before the first treatment procedure is performed to allow the application of the best treatment at the time of the primary treatment. But also for relapse or metastatic disease the same principals apply. The best approach for a multidisciplinary strategy decision is the interdisciplinary meeting of experts (multidisciplinary team), either by teleconference or preferably by direct interaction after having seen the patient. However, the multidisciplinary approach per se is only of relevance if the involved specialists are experts in their fields and are aware of the most recent and optimal treatment strategy in their individual discipline. Member of a multidisciplinary team, even if not experienced in part, will train together to improve the quality of the treatment and the cooperation. The multidisciplinary approach is today an essential requirement of the management of patients with solid tumors.

315 INVITED The impact of MDT meetings on cancer patient management

A. Ramirez¹. ¹St Thomas Hospital, Cancer Research UK London Psychosocial Group 3rd Floor Adamson Centre, London, United Kingdom

Multidisciplinary team working has been implemented in cancer care systems throughout much of Europe, the USA and Australia, without a clear evidence base for its effectiveness. The introduction of multidisciplinary teams has been based upon the rationale that as the management of cancer becomes more complex it is important to involve all key professional groups in individual clinical decision making for patients. The widespread introduction of multidisciplinary teams meetings illustrates a recurring paradox in the modern healthcare systems: we demand an evidence base for individual clinical decisions, but not for overall organisational decisions. Based on a review of the current state of knowledge regarding the effectiveness of multidisciplinary team working in cancer, it appears that delivering cancer care in multidisciplinary teams leads to more rigorous decision-making processes, but not yet necessarily more patient-centred care. There is accumulating evidence that the introduction of multidisciplinary teams meetings has improved outcomes for patients with cancer, as well as their experience of care; some teams work more effectively than others; and participation in multidisciplinary teams meetings may increase team members' job satisfaction.

It is too late for randomised trials to further evaluate the effectiveness of multidisciplinary teams; they are so firmly woven into the fabric of clinical practice that is beyond unpicking. There is nevertheless a large and challenging research agenda to demonstrate their benefit for patient care. Evidence for the variation in the quality of cancer multidisciplinary teams is mostly anecdotal. We need to identify dysfunctional teams and using, the lessons from effective teams, improve their cohesion and performance. For this we need to determine the characteristics of high or low performing teams. Although there is relatively little firm evidence, we have an emerging clinical consensus about the key features. We need to develop approaches to measuring team functioning reliably in terms of the quality of clinical decision-making, patient's experience of care, clinical outcomes and the working lives of team members. We need to devise and implement packages that support and sustain all those who participate in multidisciplinary teams, including the different medical specialists, nurses and coordinators. Lessons learned from cancer may support the implementation of multidisciplinary teamworking in other disease areas.

Scientific Symposium (Thu, 24 Sep, 09:00–11:00) Communication crisis in oncology

316 INVITED Managing the family which demands that the patient not to be told

N.I. Cherny¹. ¹Shaare Zedek Medical Center, Medical Oncology and Palliative Medicine Service, Department of Oncology, Jerusalem, Israel

Requests by family members to withhold information relating to the patients diagnosis or prognosis are very common. Data from the recent ESMO survey of oncologists' communication indicates that these requests are far more common than requests from the patient to limit information to the told to the family. Though these requests are more common in non Western cultures, they are universal. Oncologists demonstrate marked variability in the way in which they respond to such requests. Although most oncologists will try to convince the family members that it is in the patient interests that they receive information about their illness, many comply with these request without verifying the patients communication preferences. ESMO data indicate that local professional norms regarding appropriate physician behaviors is the strongest determinant of how physicians respond to these requests, and that the physicians likelihood of cooperating with a collusive request is also influenced by their training in breaking bad news, the country in which they work and the frequency with which they are barraged to requests to withhold information. Strategies will be presented to help clinicians work with families, explore the information preferences of their patients and manage the delicate balance of dealing with stakeholders who may have different desires an expectations regarding what should or should not be explained. Cultural and ethical issues will be addressed. Common errors in will be discussed: particularly those related to cultural stereotyping and avoidance.

318 INVITED Raising end of life issues in patients with advanced cancer

L. Deliens¹. ¹Vrije Universiteit Brussel, End-of-life care Research Group, Brussels, Belgium

Increasingly, patients themselves are expected to decide when and how they die. Respect for patients' autonomy and shared decision-making are seen as requisites for high-quality care at the end of life. Therefore patients need to be optimally informed, even when they are incurable or terminally ill and confronted with medical decisions at the end of life. Some countries have drafted laws to guarantee this right on information for the terminally ill.

The aim of this presentation is to explore firstly, *what kind of information* physicians should give to incurable patients and what kind of information these patients are expecting to receive? Secondly, *how and when* physicians should raise end-of life issues and what *problems* they might encounter. Finally, possible solutions are suggested to improve the informing the incurable patient.

For incurable cancer patients, truth-telling includes information about the potential futility of curative treatment, their impending death, possible clinical pathways to death, and the possible impact of end-of-life decisions on these pathways. Research on the information preferences of advanced cancer patients show that most patients want to be fully informed about their chances of cure and life expectancy. Fewer but still a majority are open to information about palliative care and end-of-life decisions.

For the physician, telling the whole truth and nothing but the truth to terminal patients is not an easy task. While most physicians inform advanced cancer patients about diagnosis and treatment options they do this less with regard to prognosis, and far less with regard to end of life issues. Specific problems are a lack of patient-centeredness and information that is not tailored to the patients' age, educational level, culture and social background.

Possible suggestions to deal with these problems are to 'dose the truth' by giving bad news step by step, to regularly check the patient specific information preferences. Physicians should however be aware that providing 'optimal' information on end of life issues is challenging. They also should be prepared to avoid some common pitfalls.

Conclusion: while there is consensus about giving information on diagnosis and treatment options, information on end of life issues is much more problematic. Therefore this topic should receive more attention in communication training of caregivers.