Multidisciplinary care—what are the medicolegal implications?

WORKSHOP REPORT AND RECOMMENDATIONS

JUNE 2007

PREPARED BY THE NATIONAL BREAST CANCER CENTRE

FUNDDED BY THE AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING
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ACKNOWLEDGEMENTS

The National Breast Cancer Centre (NBCC) gratefully acknowledges the support of all the individuals and groups who contributed to the development of this report, in particular the individuals who attended and participated in the workshop. Special thanks go to the workshop Chair, the Hon. Justice Margaret Beazley AO from the Supreme Court New South Wales, and to the speakers and panellists.

Speakers
Ms Jane Jones    Department of Human Services, VIC
Dr Mark Sidhom   Liverpool Hospital, NSW
Ms Sue Sinclair  Cancer Institute NSW

Panellists
Ms Sarah Byrne   Australian Medical Association
Ms Tracey Cosgrove Cancer Nurses Society of Australia
Clinical Associate Professor Peter Grant The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Dr Elizabeth Hindmarsh The Royal Australian College of General Practitioners
Ms Alex Hutley    United Medical Protection
Associate Professor Ian Kerridge Centre for Values Ethics and the Law in Medicine
Dr Craig Lewis   Medical Oncology Group of Australia
Mr Bill Madden    Slater & Gordon, Lawyers
Dr Adrienne Morey The Royal College of Pathologists of Australasia
Ms Domini Stuart  Breast Cancer Network Australia

Funding
The National Breast Cancer Centre is funded by the Australian Government Department of Health and Ageing.

National Breast Cancer Centre Staff
The following staff were involved in planning and implementing the workshop and in the development of this report:
Dr Alison Evans
Ms Holly Goodwin
Ms Janice O’Brien
Dr Helen Zorbas
BACKGROUND

Multidisciplinary care has been shown to improve care and outcomes for patients with cancer and is incorporated into national and state/territory clinical practice guidelines, frameworks and plans across Australia. Work conducted by the National Breast Cancer Centre (NBCC)\(^1\) and others has highlighted a number of issues relating to the medicolegal implications of a team approach to cancer care that could benefit from clarification. The introduction of new Medicare Benefits Schedule (MBS) item numbers for specialists participating in multidisciplinary treatment planning meetings in November 2006 has added further impetus for the need for clarification in this area.

To this end, the NBCC held a workshop of clinical, legal and ethical experts in March 2007 with the aim of developing consensus advice about the potential medicolegal implications of a multidisciplinary approach to cancer care.

OVERVIEW

OBJECTIVE
The objective of the workshop was to provide guidance for health professionals and health services about medicolegal aspects of a multidisciplinary approach to cancer care. The workshop aimed to develop consensus advice and recommendations for health services, teams and individuals that will achieve best outcomes for patients while also providing appropriate protection for multidisciplinary team members and health services.

Areas identified in which guidance was required included:
- informed patient consent – including financial consent
- professional liability for health professionals participating in a multidisciplinary team
- documentation of dissenting views in a multidisciplinary team meeting
- involvement of the patient and how to incorporate patient views in treatment planning.

PRE-WORKSHOP SURVEY
Prior to the workshop, a survey was distributed by email to 48 health professionals and health service administrators involved in multidisciplinary cancer care teams nationally in the public and private sectors. A total of 16 responses were received. The majority of respondents indicated that guidance would be useful in the areas of patient consent (n=13), financial consent (n=12), personal indemnity (n=15) and dissenting views (n=13).

The pre-workshop survey results are provided in Appendix 1.

WORKSHOP
The NBCC convened a half-day workshop on 2 March 2007 in Sydney. The workshop was facilitated by the Hon. Justice Margaret Beazley AO, Supreme Court New South Wales. The program included an introduction and overview of work undertaken to date around medicolegal aspects of multidisciplinary care and expert panel discussions about issues regarding patient consent and liability of health professionals. This was followed by small group work and facilitated discussion to agree on appropriate guidance for health services about the medicolegal aspects of multidisciplinary care.

The workshop program is provided in Appendix 2.

ATTENDANCE
Workshop attendees provided medical, legal, ethical and patient perspectives.

Attendees included representatives from:
- Australian Medical Association
- Breast Cancer Network Australia
- Cancer Australia
- Cancer Nurses Society of Australia
- Cancer Institute NSW
• Cancer Voices Australia
• Centre for Values Ethics and the Law in Medicine
• Clinical Excellence Commission NSW
• Clinical Oncological Society of Australia
• Commonwealth Department of Health and Ageing
• Department of Human Services, Victoria
• Medical Oncology Group of Australia
• Slater & Gordon, Lawyers
• The Royal Australian College of General Practitioners
• The Royal Australasian College of Surgeons
• The Royal College of Pathologists of Australasia
• The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
• The Royal Australian and New Zealand College of Radiologists
• United Medical Protection.

An attendance list is provided in Appendix 3.
WORKSHOP OUTCOMES

The workshop identified a number of issues that should be considered by multidisciplinary teams in relation to medicolegal issues, and generated consensus recommendations to guide health services and multidisciplinary teams. Central to all discussions was the need to maintain best patient outcomes as the key guiding principle. Attendees agreed that medicolegal issues should not be viewed as a barrier to multidisciplinary care.

Overall, while legal precedent in this area is limited, multidisciplinary team meetings were considered to carry a low level of medicolegal risk for health professionals. The key recommendations focussed on improving communication with the patient, improving documentation and strengthening the processes that support multidisciplinary care. It was acknowledged that while these recommendations may have resource implications for some teams, the use of generic proformas and templates could assist in minimising the work required to implement them.

TEAM ROLE AND FUNCTION

It was acknowledged that there are a number of models of multidisciplinary care with variations relevant to the local setting. Regardless of the model used, it was agreed that a clear definition of the role and membership of the team, together with defined protocols for the conduct of meetings, including criteria about which cases are discussed, are important factors in addressing medicolegal issues. This section covers overall protocols for teams and meetings. For specific recommendations for individual clinicians see sections on patient consent and professional liability.

RECOMMENDATIONS

- The membership of the team and the purpose of the multidisciplinary meeting should be defined and documented in each clinic or hospital.
- The protocols and criteria used by the multidisciplinary team should be transparent.

WHAT DOES THIS MEAN IN PRACTICE?

- Each team should define and document the membership of the team, including the core disciplines integral to treatment planning for the cancer type(s) discussed by the team and non-core disciplines that may be relevant to some, but not all cases.
- Each team should define and document the purpose of the team meeting, eg tumour board, prospective treatment planning.
- A protocol should be agreed and documented about attendance at meetings by non-clinical members, in particular representatives from pharmaceutical companies.

Suggestion: Workshop attendees suggested that while pharmaceutical representatives may address attendees at the beginning or end of the meeting, they should not be present for case discussions.
• The criteria for determining which cases will be discussed by the multidisciplinary team should be agreed and documented. If a case is not discussed at a multidisciplinary team meeting, the reason(s) should be documented in the patient record.

PATIENT CONSENT
It was agreed that privacy of patient health information is the key issue underlying patient consent. A range of practices were described for obtaining consent from a patient for his/her case to be discussed by a multidisciplinary team, including use of the generic consent form signed on admission to hospital, a verbal discussion with the patient about the multidisciplinary meeting and a signed consent form giving permission for the case to be discussed. It was agreed that some specific issues around the multidisciplinary team may not be covered by current generic consent forms signed when a patient is first admitted to hospital. It was also emphasised that following a diagnosis of cancer, patient comprehension may be limited due to anxiety. Health professionals have a responsibility to explain the steps by which care will be planned and managed in simple terms that can be understood easily.

RECOMMENDATIONS
• Informed patient consent should be obtained before a patient’s case is discussed by the multidisciplinary team.
• Informed consent should be obtained regardless of whether the patient will be billed by clinicians for the case discussion (see section on the MBS items).
• Patients should understand what they are consenting to – it is important to make the distinction between consent to have a case discussed by a multidisciplinary team for the purpose of treatment planning and consent to a particular procedure or treatment.
• Patients should understand the format of the multidisciplinary team – the disciplines who will be involved in the discussion and other non–participating disciplines who may be present, eg medical students.
• Patients should understand what information about their current health and medical history will be shared with the team, including their psychosocial history if relevant.
• Patients should be given the opportunity to identify any information they do not wish to be shared with the team.

WHAT DOES THIS MEAN IN PRACTICE?
• The treating clinician is responsible for gaining informed consent from the patient prior to presenting the case at a multidisciplinary meeting. The process for obtaining informed consent may be delegated to another member of the team.
• Patient consent may be written or verbal according to local protocols. Regardless, the fact that consent has been given should be documented in the patient record.
• Information provided to patients should use simple terminology and avoid jargon.
• Patients should be given time to consider whether they consent to having their case discussed, and the opportunity to ask questions.
IDENTIFICATION OF PATIENTS IN MEETINGS
An issue related to patient consent was the identification of patients within a multidisciplinary team setting. It was agreed that patients discussed during multidisciplinary meetings are protected by the same principles of doctor–patient confidentiality as they would be in an individual consultation.

RECOMMENDATION
• It is unnecessary to de-identify patients during multidisciplinary team discussions.

WHAT DOES THIS MEAN IN PRACTICE?
• Patients can be identified in the meeting, eg by name or initials and date of birth.
• Members of the multidisciplinary team should have the option to declare a conflict of interest and to opt out of decision making, eg in circumstances where the patient is known personally to the team member.

PROFESSIONAL LIABILITY
Implications for health professionals participating in a multidisciplinary team were discussed. Outcomes from multidisciplinary meetings are recommendations or options to be discussed with the patient by the treating clinician. It was emphasised that the recommended treatment plan should not be implemented until the patient has agreed to a course of action and following appropriate counselling that complies with contemporary standards of patient disclosure. Health professionals who participate in multidisciplinary team meetings carry responsibility for their actions within that team akin to other clinical responsibilities. A duty of care will arise even though there may be no personal contact with the patient.

RECOMMENDATIONS
• An accurate and comprehensive presentation of the patient’s medical history and diagnostic tests should be provided at the multidisciplinary meeting.
• Health professionals participating in multidisciplinary care meetings share responsibility for the decisions made at such meetings even though individual health professionals may have no personal contact with patients whose cases are discussed.
• Team members who contribute to a treatment recommendation share responsibility for that recommendation within their area of expertise.
• If an opinion from a discipline considered essential to the treatment of a patient is not available during the meeting, referral outside the team meeting should occur before a treatment plan is recommended.

Suggestion: Develop a generic patient information sheet describing the role and membership of the multidisciplinary team, the types of information that may be shared in the meeting and the importance of both clinical and psychosocial information in making treatment decisions.
• Team members who disagree with a proposed recommendation, or who have an alternative recommendation, should raise this during the meeting and this should be documented.

• Non-participating team members who are present in an observational capacity for a particular case discussion do not share responsibility for the recommendation.

WHAT DOES THIS MEAN IN PRACTICE?
• The core team principally responsible for decision making should be identified and documented by discipline.

• Attendance at each meeting should be recorded in writing both by discipline and name, including non-participating members.

Suggestion: Use a proforma attendance register to record meeting attendance. The register can be circulated for completion during the meeting or completed by a designated member.

• It is the responsibility of the treating clinician to ensure all relevant and accurate patient information, including the patient medical history and diagnostic results such as pathology reports and slides, imaging films and scans, blood test results and previous treatment plans are available and presented at the multidisciplinary meeting.

• It is the responsibility of the treating clinician to present the case information at the meeting and to discuss the recommended treatment plan with the patient after the meeting.

• The meeting chair or lead clinician should provide a summary/overview at the end of each case discussion to confirm consensus or provide an opportunity for final comments/dissenting views to be raised.

• The recommended treatment plan should be documented in the patient record. Where more than one option is recommended or where there are dissenting views these should also be recorded.

Suggestion: Use a proforma to document the recommended treatment plan, including options and dissenting views.

Suggestion: For hospitals with electronic patient records, recording the recommended treatment plan electronically during a meeting may be useful.

• The final treatment plan agreed to by the patient should be documented in the patient record and communicated to the patient’s general practitioner and other relevant treating clinicians, including details of any changes due to patient preference.

Suggestion: A proforma for communicating the final treatment plan with general practitioners may be useful.
MEDICARE BENEFIT SCHEDULE ITEM NUMBERS
In November 2006, two new MBS item numbers were introduced to support specialists in attending and participating in multidisciplinary treatment planning meetings for cancer patients. Attendees discussed the impact of the introduction of the MBS items on medicolegal aspects of multidisciplinary care.

RECOMMENDATIONS
• The use of the MBS item numbers allowing clinicians to bill patients for their attendance at a multidisciplinary meeting does not affect the clinician’s potential liability.
• Health professionals carry responsibility for their actions within that team akin to other clinical responsibilities, regardless of whether the patient is billed.

Suggestion: An information sheet has been developed by the NBCC to assist in implementing the MBS item numbers. A copy is provided in Appendix 4.

FURTHER ISSUES
Further to the workshop discussion, the issue of incorrect information being presented at a multidisciplinary care meeting was considered. As team members can only make decisions on information that is presented at the time of the meeting, it is essential that the treating clinician provide an accurate and comprehensive overview of the case. In addition, the issue of incorrect or inadequate information provided to patients as a result of a multidisciplinary meeting was also considered.

RECOMMENDATIONS
• It is the responsibility of the treating clinician to ensure the information presented at the meeting is accurate and all diagnostic results are available for review and discussion to inform the recommended treatment plan.
• It is the responsibility of the treating clinician to give feedback to the patient regarding the recommended treatment plan and to provide adequate counselling regarding the risks and benefits of treatment and the possible alternatives.
APPENDIX 1

PRE-WORKSHOP SURVEY

1. Have you or your multidisciplinary team sought guidance or developed guidelines on the following issues?

   a) Process for obtaining informed consent by patients for their case to be discussed by a multidisciplinary team

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of responses (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11 (73%)</td>
</tr>
<tr>
<td>No</td>
<td>4 (27%)</td>
</tr>
</tbody>
</table>

   Comments included:
   - We discuss the MDT meeting rationale with the patient and the consent is signing a medicare claim for this item.
   - Agreed protocol for consenting brochure for patients, however, no audit process.
   - We already get the patients to sign consent that is generic enough to cover this at the first consultation when they are informed of our processes to discuss their case.
   - Obtaining verbal consent, providing the patient with information sheet statement on the listing participants information sheet reinforcing MDT members commitment to confidentiality.
   - In the development process at present.

   b) Process for obtaining informed financial consent by patients for their case to be discussed by a multidisciplinary team

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of responses (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>No</td>
<td>14 (93%)</td>
</tr>
</tbody>
</table>

   c) Implications for personal indemnity in a shared decision-making process

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of responses (n=16)</th>
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<tbody>
<tr>
<td>Yes</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>No</td>
<td>12 (75%)</td>
</tr>
</tbody>
</table>
Comments included:

- Decision was that the primary physician/specialist can choose to ignore this advice therefore they are still the individual who is responsible for care. If they do not want to follow the team decision they offer to refer the patient to another member of the team.
- Discussed and some literature perused.
- Recently began to explore liability, risk management process, documenting in the patient notes in MDT making decision who concurs.

d) Process for formal documentation of meeting outcomes, including dissenting views

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of responses (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12 (75%)</td>
</tr>
<tr>
<td>No</td>
<td>4 (25%)</td>
</tr>
</tbody>
</table>

Comments included:

- We used a standardised form for collection of information. This information is transcribed (including variations in opinion) into a document which is filed in the health record.
- Process for documentation, but not for dissenting views.
- Not enough clerical support to be able to do this (zero clerical support at the meetings to record this). Funding for this important risk management function is an issue. A referral or request to treat is usually filled out at the meeting and people make notes on the list of patients to be discussed for their own information and as a memory jogger.
- Formal dictated report by designated member secretary (surgeon) after each case; bound and copied to GP, treating doctors, core roles and unit file (for record).
- Recommendations documented in hard copy and recorded in electronic patients records and electronic cancer registry. Have never experienced a dissenting view.
- Still formulating forms, work underway.

2. Do you think that guidance on these topics would be helpful?

<table>
<thead>
<tr>
<th>Number of responses (n=16)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed patient consent</td>
<td>13 (81%)</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Informed financial patient consent</td>
<td>12 (75%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Personal indemnity within a multidisciplinary team</td>
<td>15 (94%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Documentation of dissenting views</td>
<td>13 (81%)</td>
<td>3 (19%)</td>
</tr>
</tbody>
</table>
3. Are there additional areas around the medicolegal implications of multidisciplinary care where you think guidance would be beneficial?

Comments included:
- Allied health and nursing involvement in this decision making process - legal responsibilities. Electronic and telephone advice to patient, GP and other MDC members, eg Silver Chain nurses or regional coordinators.
- Implementation of a generic MDT proforma specific to tumour stream for improved documentation.
- Many of our teams are in the forming stages so any guidance in these areas would be greatly appreciated.

4. What is your area of specialty?

Survey respondents included:
- Medical oncology (4)
- Radiation therapy
- Colorectal surgery
- Head & neck cancer
- Surgeon (2)
- Anatomical pathology
- Breast care nurse
- Breast surgeon
- General surgeon
- Breast cancer
- Whole of cancer & palliative care.

5. Please indicate the sector your practice is in:

<table>
<thead>
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<tbody>
<tr>
<td>Public</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Private</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Both</td>
<td>9 (56%)</td>
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</table>

6. Are you part of a multidisciplinary team for cancer care at present?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of responses (n=15)</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14 (93%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (7%)</td>
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</table>
APPENDIX 2

WORKSHOP PROGRAM

Multidisciplinary care – what are the medico-legal implications?

Friday 2 March 2007, 1.00–5.00pm
Centennial Room, Stamford Plaza Sydney Airport, Mascot, NSW

<table>
<thead>
<tr>
<th>Start</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.30pm</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1.00pm</td>
<td>Welcome and aims</td>
<td>The Hon. Justice Margaret Beazley AO</td>
</tr>
<tr>
<td>1.10pm</td>
<td>Background</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• MDC: current context</td>
<td>Dr Helen Zorbas</td>
</tr>
<tr>
<td></td>
<td>• Outcomes from survey of</td>
<td>Dr Mark Sidhom</td>
</tr>
<tr>
<td></td>
<td>health professionals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• State initiatives</td>
<td>Cancer Institute NSW</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Department of Human Services, VIC</td>
</tr>
<tr>
<td>1.50pm</td>
<td>Scenario 1 ‘Patient consent’</td>
<td>Panel discussion facilitated by Justice Margaret Beazley</td>
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<tr>
<td></td>
<td>Including legal precedents</td>
<td></td>
</tr>
<tr>
<td>2.20pm</td>
<td>Scenario 2 ‘Indemnity issues’</td>
<td>Panel discussion facilitated by Justice Margaret Beazley</td>
</tr>
<tr>
<td></td>
<td>Including legal precedents</td>
<td></td>
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<tr>
<td>2.50 pm</td>
<td>Afternoon Tea</td>
<td></td>
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<tr>
<td>3.10pm</td>
<td>Development of guiding principles</td>
<td>Small group work: each group to take different perspective - health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>service/hospital, clinician (GP or specialist), consumer</td>
</tr>
<tr>
<td>4.30pm</td>
<td>Summary</td>
<td>Justice Margaret Beazley</td>
</tr>
<tr>
<td>4.45pm</td>
<td>Next steps</td>
<td>Dr Helen Zorbas</td>
</tr>
<tr>
<td>5.00pm</td>
<td>Close</td>
<td></td>
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</tbody>
</table>
APPENDIX 3

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hon. Justice Margaret Beazley AO</td>
<td>Supreme Court Judge (Chair)</td>
<td>Supreme Court of NSW</td>
</tr>
<tr>
<td>Mr John Buckingham</td>
<td>Breast Surgeon</td>
<td>Calvary Clinic, ACT (representing RACS)</td>
</tr>
<tr>
<td>Ms Sarah Byrne</td>
<td>Director, Legal Services</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>Ms Tracey Cosgrove</td>
<td>Chairperson, CNSA Sydney Division</td>
<td>Cancer Nurses Society of Australia</td>
</tr>
<tr>
<td>Mr Michael Denahy</td>
<td>Researcher</td>
<td>Supreme Court of NSW</td>
</tr>
<tr>
<td>Dr Alison Evans</td>
<td>Acting Deputy Director</td>
<td>National Breast Cancer Centre</td>
</tr>
<tr>
<td>Ms Rita Evans</td>
<td>National Manager</td>
<td>Cancer Australia</td>
</tr>
<tr>
<td>Ms Holly Goodwin</td>
<td>Project Officer</td>
<td>National Breast Cancer Centre</td>
</tr>
<tr>
<td>Associate Professor Peter Grant</td>
<td>Head, Gynaecological Oncology Department</td>
<td>Mercy Hospital for Women, VIC (representing RANZCOG)</td>
</tr>
<tr>
<td>Dr Rona Ham</td>
<td>Medical Officer</td>
<td>Cancer Australia</td>
</tr>
<tr>
<td>Dr Libby Hindmarsh</td>
<td>General Practitioner</td>
<td>representing RACGP</td>
</tr>
<tr>
<td>Professor Clifford Hughes</td>
<td>Chief Executive Officer</td>
<td>Clinical Excellence Commission, NSW</td>
</tr>
<tr>
<td>Ms Alex Hutley</td>
<td>Senior Solicitor</td>
<td>United Medical Protection</td>
</tr>
<tr>
<td>Ms Jane Jones</td>
<td>Manager, Multidisciplinary Care Project</td>
<td>Department of Human Services, VIC</td>
</tr>
<tr>
<td>Dr Megan Keaney</td>
<td>National Claims Manager; Chair of NBCC Board</td>
<td>United Medical Protection</td>
</tr>
<tr>
<td>Associate Professor Ian Kerridge</td>
<td>Director, Centre for Values Ethics &amp; Law in Medicine</td>
<td>The University of Sydney, NSW</td>
</tr>
<tr>
<td>Associate Professor Rosemary Knight</td>
<td>Head of the School of Public Health and Community</td>
<td>The University of New South Wales</td>
</tr>
<tr>
<td>Dr Craig Lewis</td>
<td>Senior Staff Specialist, Medical Oncology</td>
<td>Prince of Wales Hospital, NSW (representing MOGA &amp; RACP)</td>
</tr>
<tr>
<td>Mr Bill Madden</td>
<td>Solicitor (Accredited Specialist)</td>
<td>Slater &amp; Gordon Lawyers, NSW</td>
</tr>
<tr>
<td>Ms Julie Marr</td>
<td>Director, Cancer Control Section</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>Ms Margaret McJannett</td>
<td>Executive Director</td>
<td>Clinical Oncological Society of Australia</td>
</tr>
<tr>
<td>Ms Joy McLaughlin</td>
<td>Assistant Secretary, Chronic Disease &amp; Palliative Care</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>Associate Professor Chris Milross</td>
<td>Head, Radiation Oncology</td>
<td>Royal Prince Alfred Hospital, NSW (representing RANZCR)</td>
</tr>
<tr>
<td>Dr Adrienne Morey</td>
<td>Director, Anatomical Pathology</td>
<td>St Vincents Hospital, NSW (representing RCPA)</td>
</tr>
<tr>
<td>Ms Bronwyn Morris</td>
<td>Project Manager, Patient Safety</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>Ms Janice O’Brien</td>
<td>Project Assistant</td>
<td>National Breast Cancer Centre</td>
</tr>
<tr>
<td>Dr Mark Sidhom</td>
<td>Radiation Oncologist</td>
<td>Liverpool Hospital, NSW</td>
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<tr>
<td>Ms Sue Sinclair</td>
<td>Director, Cancer Services and Education</td>
<td>Cancer Institute NSW</td>
</tr>
<tr>
<td>Dr Andrew Spillane</td>
<td>Breast Surgeon</td>
<td>Sydney Breast Cancer Institute RPA</td>
</tr>
<tr>
<td>Ms Domini Stuart</td>
<td>BCNA Representative</td>
<td>Breast Cancer Network Australia</td>
</tr>
<tr>
<td>Mr John Stubbs</td>
<td>Executive Officer</td>
<td>Cancer Voices Australia</td>
</tr>
<tr>
<td>Professor Martin Tattersall AO</td>
<td>Director, Medical Psychology Research Unit</td>
<td>The University of Sydney, NSW</td>
</tr>
<tr>
<td>Ms Robyn Thomas</td>
<td>Project Officer, Collaboration and Information</td>
<td>Cancer Institute NSW</td>
</tr>
<tr>
<td>Dr Helen Zorbas</td>
<td>Director</td>
<td>National Breast Cancer Centre</td>
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Information about the new MBS items for multidisciplinary cancer care

On 1 November 2006, two new Medicare Benefit Schedule items were introduced providing rebates for participation by medical practitioners in multidisciplinary treatment planning meetings for cancer patients. The following information has been developed by the National Breast Cancer Centre to assist multidisciplinary teams in implementing the items.

Who can claim the items?

- **Item 871** can be claimed by a medical practitioner from any area of medical practice (defined in the item descriptor as a specialist, consultant physician or general practitioner) who is leading and coordinating a multidisciplinary case conference to develop a multidisciplinary treatment plan for a patient with cancer. The lead practitioner is responsible for ensuring that records of the meeting are kept and that the patient is informed of the outcomes from the meeting.

- **Item 872** can be claimed by a medical practitioner from any area of medical practice (defined in the item descriptor as a specialist, consultant physician or general practitioner) who is participating in a multidisciplinary case conference to develop a multidisciplinary treatment plan for a patient with cancer. Only treating medical practitioners can claim the items – that is those who have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months.

Under this definition, a 'treating medical practitioner' would include the pathologist or radiologist who provided a formal diagnosis of the patient's cancer prior to the meeting, or a radiation oncologist who will prescribe radiotherapy for the patient but does not expect to have contact with the patient until some months after the meeting.

Non-treating clinicians, allied health providers and support staff are not eligible to claim the item. This includes doctors who may provide an opinion in the meeting but who are not members of the patient's treatment team.

What meetings do the items apply to?

The items apply to discussions during a multidisciplinary team meeting held for the purpose of developing a cancer treatment plan. The items should not be billed against community or discharge case conferences. Meetings may be face-to-face or held via teleconference or videoconference.

What is the minimum number of practitioners who should be involved in the meeting?

The multidisciplinary meeting must involve at least four medical practitioners (including the lead practitioner). Participants must be from different areas of medical practice and may include general practice. Allied health practitioners must also be present.

Other relevant MBS items

- **Items 721–731**: multidisciplinary care plans (medical practitioner other than specialist or consultant physician)
- **Items 734–771**: community/discharge/residential aged care case conferences (medical practitioner other than specialist or consultant physician)
- **Items 820–838**: community/discharge case conferences (consultant physician)
- **Items 855–866**: community/discharge case conferences (consultant psychiatrist)
- **Item 880**: case conference (consultant physician in geriatric or rehabilitation medicine)

Where to go for further information

Information about the new MBS items for multidisciplinary care

- **How many people can claim the item for one patient?**
  Only one medical practitioner can claim item 871 for each patient discussed at the multidisciplinary case conference. There is no limit to the number of treating medical practitioners who can claim item 872 for each patient discussed.

- **How many patients can be claimed for at one meeting?**
  There is no limit to the number of patients who can be discussed during a multidisciplinary meeting. However, discussion about each patient discussed at the multidisciplinary meeting should last at least 10 minutes.

- **Which patients do the items apply to?**
  The items apply to private patients being treated in public or private hospitals or in the community who have a malignancy of a solid organ or tissue, or a systemic cancer such as a leukaemia or a lymphoma. The items do not apply to patients whose only cancer is a non-melanoma skin cancer.

- **How many times can a patient be billed?**
  In general, it is expected that a patient will be discussed at no more than two case conferences each year. Therefore, it is unlikely that an individual patient would be billed more than twice in a year.

- **What is the schedule fee?**
  - The schedule fee for item 871 is $71 per patient
  - The schedule fee for item 872 is $33 per patient

- **Gaining patient consent**
  It is the responsibility of each billing practitioner to ensure that the patient is informed that a charge will be incurred for the multidisciplinary meeting. This task may be delegated to one member of the team representing all billing practitioners. Regardless of who gains consent, the explanation should include:
  - explaining to the patient the nature of the multidisciplinary meeting and asking the patient whether he or she agrees to the meeting taking place
  - informing the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers
  - providing an opportunity for the patient to specify what medical and personal information he or she does not want to be conveyed to the other members of the multidisciplinary care team
  - informing the patient that he or she will incur a charge for the service provided by the practitioner(s) for which a Medicare rebate will be payable
  - informing the patient of any additional costs he or she will incur.
  If consent is delegated to a member of the treatment team who is not a billing practitioner, and if the patient identifies information he or she does not wish to share with some or all members of the multidisciplinary team, the lead practitioner should be informed accordingly.

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Funded by the Australian Government Department of Health and Ageing.