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Multidisciplinary meeting for breast cancer care: EUSOMA recommendations for optimization

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ABSTRACT

Introduction: In breast cancer care multidisciplinary meetings (MDMs) are fundamental. Recently, the increasing number of patients, the complexity of cancer treatments, the shortages of specialists, and constrained hospital budgets have underscored the urgency of optimizing MDM processes to ensure that every patient benefits from thorough and timely multidisciplinary evaluation.
Material and methods: The European Society of Breast Cancer Specialists (EUSOMA) set up a multidisciplinary working group of international experts to develop consensus-based recommendations to optimize MDM management. To obtain insights into the current state of MDM organization and management within Europe and elsewhere, the experts designed and conducted an international survey.
Results: Briefly, the survey showed that most centres held a weekly MDM, either in person, online or combining the modalities, which lasted for 1−2 h. Discussion times for each case varied with its complexity. Some differences emerged between European and non- European breast cancer centres. The recommendations for improving MDM management focused on: i) timing, venue, logistics, administrative support; ii) technologies/equipment; iii) documentation; iv) planning and preparation; v) structure; vi) minutes/reporting; and viii) other issues.
Conclusion: Optimizing MDM ensures that each patient receives the most appropriate, guideline-aligned treatment, tailored to individual needs. With the present recommendations, EUSOMA wishes to support breast centres in improving and standardizing MDM management.

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1. Introduction

Evidence supporting the value of multidisciplinary discussions in oncology emerged in the late 1990s [1]. In 2000, the European Society of Breast Cancer Specialists (EUSOMA) published its first position paper outlining requirements for specialist breast cancer (BC) centres, which included recommendations for organizing multidisciplinary meetings (MDMs) [2].

Although nomenclature may vary [3] (multidisciplinary cancer conference (MCC), multidisciplinary team meeting, tumor board, multidisciplinary case management meeting), the core concept is: MDM is a structured forum in which healthcare professionals from diverse disciplines collaboratively review and plan the care of cancer patients at any stage of the disease trajectory. Indeed, a recent meta-analysis reported a significant survival advantage for patients managed within a multidisciplinary framework compared to those who were not [4]. Enhanced clinical decision-making through diverse perspectives, reduced risk of medical error, more coordinated and personalized care pathways were hypothesized to underlie this survival benefit.

Underscoring the urgency of optimizing MDM processes to ensure that every patient benefits are the increasing clinical workload and complexity of cancer treatments, shortages of specialists across various disciplines, constrained hospital budgets and the rapidly evolving landscape of diagnostic, therapeutic and palliative options. In response to these challenges EUSOMA convened a multidisciplinary working group of international experts in BC to update consensus-based recommendations so as to optimize MDM structure and function. As a European framework for MDM improvements, these recommendations could potentially be applied across other continents. Furthermore, to gain insights into the current state of MDM organization and management within and outside Europe, EUSOMA conducted an international survey.

The present paper presents the results of the survey, alongside recommendations aimed at optimizing this essential component of BC care.

2. Materials and methods

The working group discussed online the following MDM-related items: i) timing, venue, logistics, administrative support; ii) technologies/equipment; iii) documentation; iv) planning and preparation; v) structure; vi) minutes/reporting, vii) chairperson; viii) other issues.

A survey was designed to obtain a state-of-the-art picture of MDM management in breast centres, focusing on organizational/general aspects for non-metastatic and metastatic cases. It was conducted among 43/44 (97.7 %) European EUSOMA-certified breast centres and 17/50 (34.0 %) responding non-European (non-EU) breast centres from the United States, Australia, China and Brazil.

3. Results

3.1. The EUSOMA survey

Fig. 1–4 report the results. Most centres held a weekly MDM that lasted for 1–2 h. Discussion times for each case varied. In 53 % EUSOMA centres attendance was in combined modality (present or online) while 8 % were held only online. In non-EU centres, over 40 % of MDM were held only online. The Chairperson was always present in EUSOMA centres, unlike non-EU countries. Participation rates for BC nurses were usually lower in non-EU than in European MDM for non-metastatic and metastatic cases.

Electronic files and documentation were used at all EUSOMA MDM for all patients and in 94 % of non-EU countries. Differences emerged in the percentage of pre- and post-operative cases discussed in EUSOMA centres and others. Of the EUSOMA-certified centres, 33 % had a dedicated MDM for metastatic patients, compared with 55 % of non-EU centres. Fewer metastatic than non-metastatic cases were discussed in EUSOMA and non-European centres. Almost all centres worldwide were open to including BC patients in clinical trials.

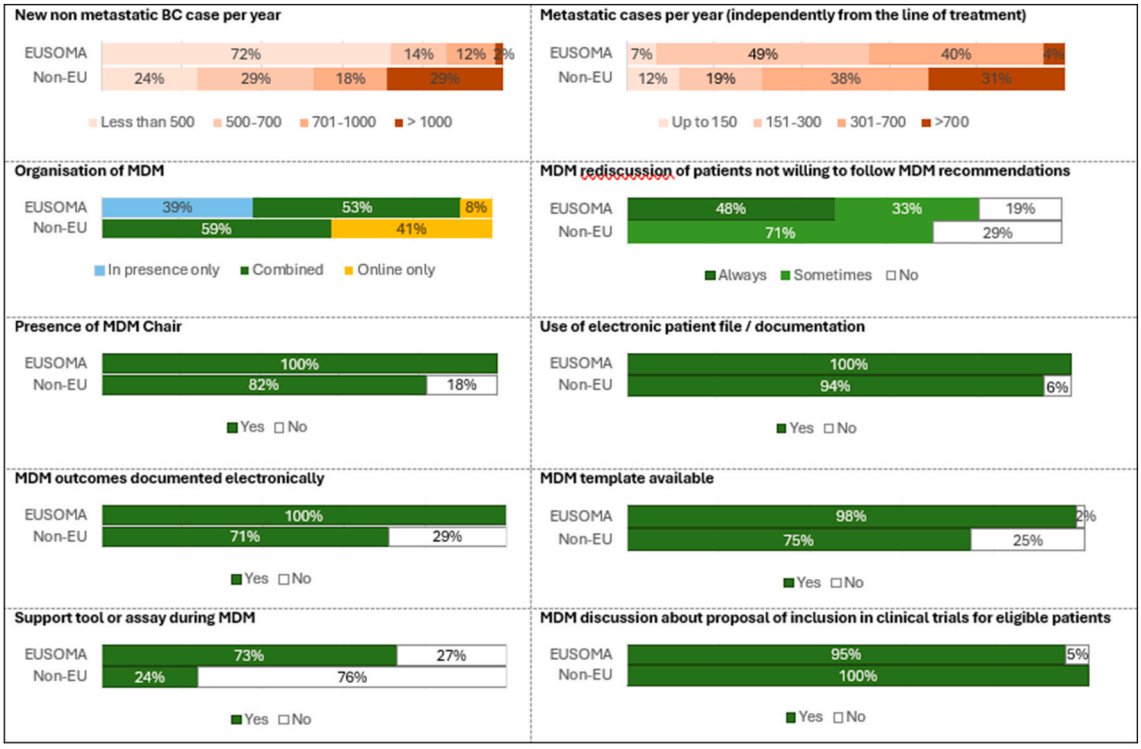

Fig. 1. MDM Organization in European Eusoma Breast Centres and in Non-EU Breast Centres (*43 respondents: European Eusoma BCs and 17 respondents: Non-Eu BCs*).

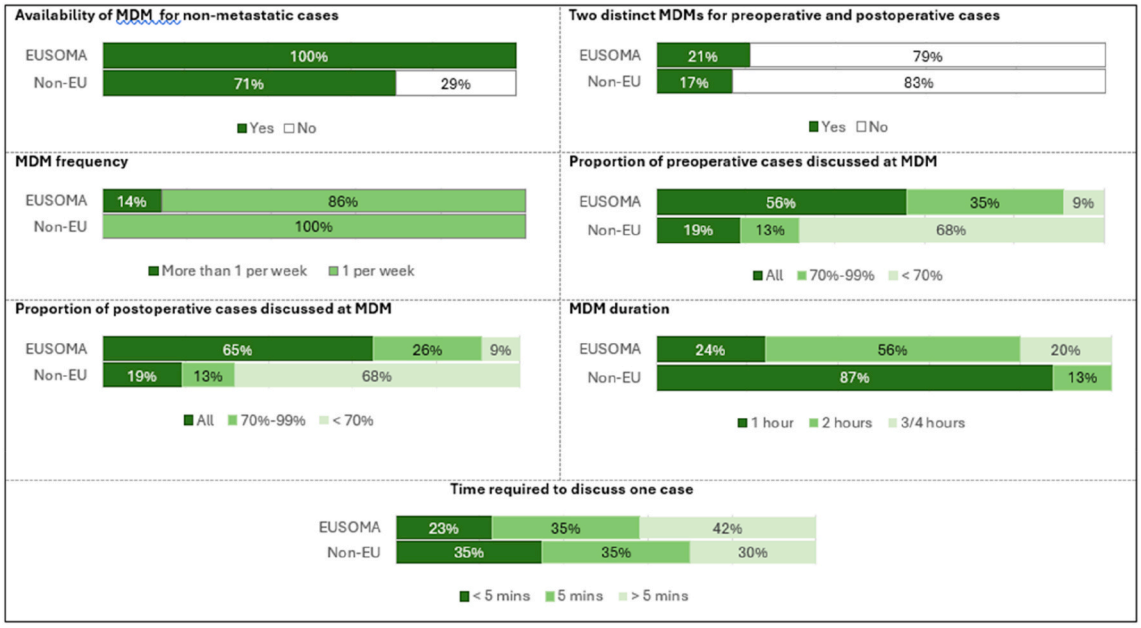

Fig. 2. Focus on non-metastatic cases (*43 respondents: European Eusoma BCs and 17 respondents: Non-EU BCs*).

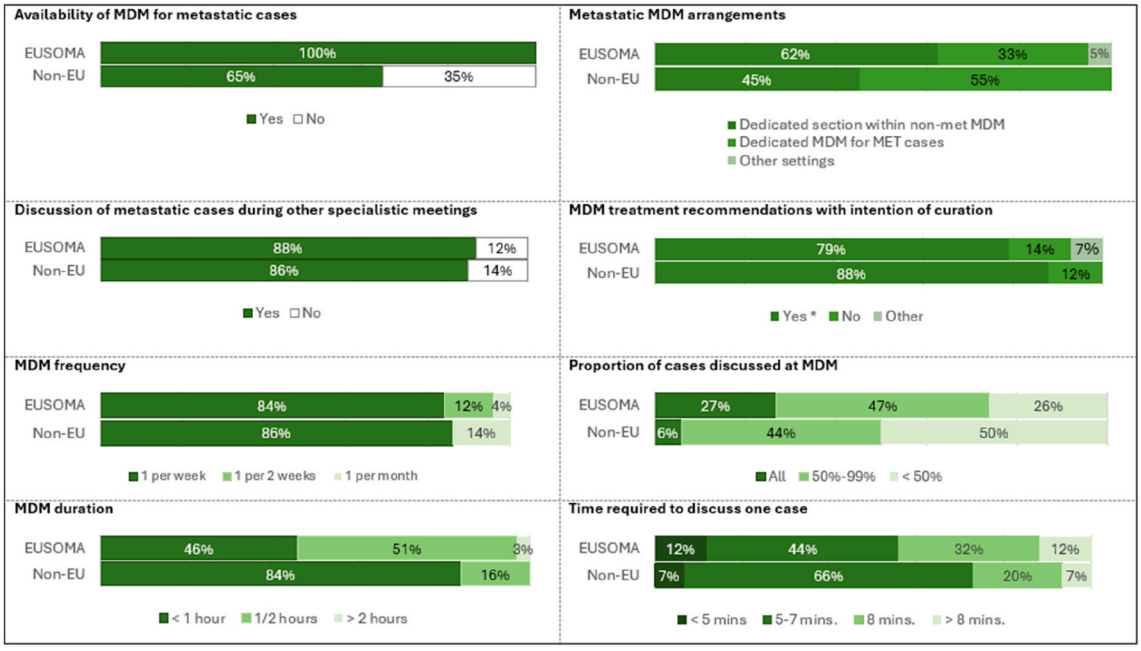

Fig. 3. Focus on metastatic cases (*43 respondents: European Eusoma BCs and 17 respondents: Non-EU Bcs*).

3.2. Recommendations for MDM optimization

3.2.1. Timing, venue, logistics, and administrative support

Key factors in MDM sustainability are regular timing and efficient logistics. To guarantee routine, optimize participation and avoid confusion MDMs should be held on the same day, in the same location at a time when participants can attend. The venue should have enough space to ensure adequate representation of all specialties and professions. Although duration depends on the number, type and complexity of cases to be discussed [5], it needs to be fixed for scheduling purposes.

MDM can be arranged in presence and/or online [6]. Both modalities are acceptable, but attendees should be encouraged to join in person.

The MDM should be run with adequate technical and administrative support for appropriate case presentations and discussions. Online participants must have access to all the information.

MDM participation, whether in person or online, must be recorded. Attendance should be validated and recognized by the local health administration for academic and training purposes and, where required, by professional regulators.

3.2.2. Technology/equipment

Technical support includes hardware and software, computers/workstations, large screens for viewing radiological and pathology images and clinical photos, microphone, adequate internet connection. All this equipment ensures running a smooth and efficient MDM. Dedicated

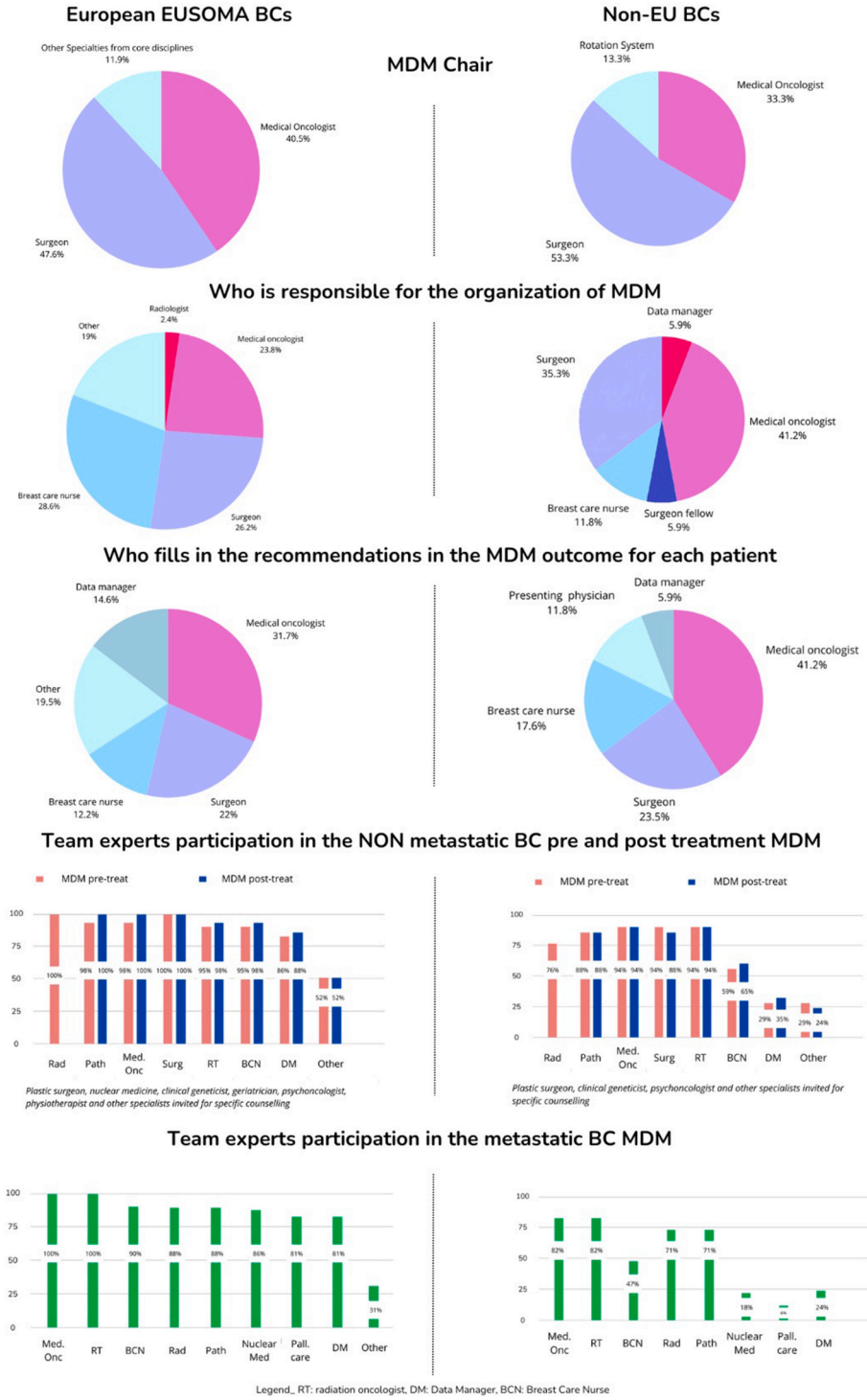

Fig. 4. MDM organization in European EUSOMA BCs and in Non-EU BCs (*43 respondents European Eusoma BCs and 17 respondents: Non-EU BCs*) Legend_RT: radiotherapist, DM: Data Manager, BCN: Breast Care Nurse.

platform supporting planning, preparation and verification of MDMs may also be considered.

3.2.3. *Documentation*

Each MDM requires an agenda, list of cases, complete documentation and data to be set up in advance [7,8] to ensure an efficient workflow that prevents delays and reduces errors.

Documents and information include relevant details of the patient's clinical history, imaging and scans, pathology reports and slides, diagnostic or lab test results and previous treatment plans, if relevant. Key clinical data may be summarized in a 'patient summary'. Details of fitness, frailty, comorbidities, broader healthcare domains and psychosocial issues should be presented.

Checklists support MDM organization and conduct as they ensure that all required documentation is available and all relevant issues are discussed and decided during the meetings.

Checklist items for each case should include:

1. essential data (pathology, imaging, clinical information on general health status, co-morbidities, surgical options, patient preferences, etc.);
2. list of "yes/no" queries (e.g., pre-operative systemic therapy, schedule options, IV access, onco-fertility consultation, psychological support and other related services);
3. candidatures for on-going clinical trials.

3.2.4. Planning and preparation

Identifying who is responsible for preparing the MDM and gathering relevant information is key. Gathering information and presenting cases can be assigned to one of several team members, including residents, fellows or trainees [7], or others (e.g., breast cancer nurses, MDT coordinators, data managers). Alternatively, individual physicians may prepare and bring information on assigned patients. Regardless of the strategy, designations must be agreed upon from the outset and backup plans set up in case of absence.

3.2.5. Structure

An MDM may be a general meeting that discusses preoperative, postoperative and metastatic cases or it may be a series of meetings dedicated to a specific topic (non-metastatic preoperative and/or postoperative, metastatic).

Categorizing the caseload will define the workflow for case discussions, establishing the maximum number and type of cases to ensure adequate discussion time for each one. Cases are defined as "simple/direct" if they are not associated with complex or discordant management options and usually require only validation/approval of the recommendation (unless unexpected problems or special issues are raised). Other cases – such as the locally advanced cancers and all cases treated with neoadjuvant systemic therapies – require an in-depth discussion.

Cases of distant metastases are discussed to evaluate and define diagnostic and treatment options including supportive/palliative care in the different stages of disease progressions [9].

3.2.6. Minutes/reporting

Recommendations, which are crucial for a well-conducted MDM, should be written out by experienced staff (e.g., administrative staff, nurses, physicians) during the meeting, be visible to all participants and modified in real-time, if needed. Recommendations answer the question and contain a conclusion, reporting a treatment plan and alternative treatment options, if available. Since they must be clear to healthcare professionals outside the core team, highly specialized acronyms and abbreviations should not be used.

After the meeting, team members who were unable to attend, should be promptly informed of the recommendations and/or trigger any investigations that need to be scheduled.

Since communicating the recommendations to the patient (and relatives, when appropriate) is also a key point, the MDM team should design a process and identify who will transmit results. Based on each country arrangement, general practitioners' involvement should be encouraged.

Electronic templates may be used as a checklist and to issue MDM recommendations [5]. Ideally, they should be equipped with specific interfaces and drop-down menus for each main category related to the different phases of the patient journey, including whether the patient complies or not with MDM recommendation. Lack of compliance needs to be evaluated and analyzed.

For patients with advanced or inoperable breast cancer, a dedicated template should outline loco-regional and systemic treatments, disease response outcomes, recurrence timing, disease sites at progression, imaging and blood test results (when relevant).

3.2.7. MDM chairperson

The chairperson must ensure that each specialist attending the MDM participates in the discussion by sharing viewpoints and expressing opinions. Since mutual respect and good group dynamics are essential, the chairperson must be ready to resolve conflicts [10].

Careful time management is essential, so that all cases are discussed, keeping in mind times will vary with the complexity of cases. Since knowledge is crucial for optimal discussions, the chairperson must be aware of updated guidelines, benefits and harms of treatment options, and ongoing clinical trials the patient can be enrolled in. This will provide educational benefits, foster inter-professional relationships and facilitate consensual clinical decision-making [10].

The chairperson's role is important when applying new clinical practices that might deviate from guidelines but are supported by recent publications.

In case of complex clinical problems or grey areas, the chairperson can ask the team to review the literature, allowing the case to be discussed again in the next meeting. If consensus is difficult to achieve, the chair could suggest asking for a second opinion e.g., from a reference center.

Finally, rotation of different health professionals in the position of chairperson may be beneficial.

3.3. Other issues

3.3.1. Changes in decision-making

The MDM team should monitor the patient's diagnostic and therapeutic pathway and modify preceding decisions in accordance with new clinical situations. Since such cases increase the MDM workload, a policy should be formulated to identify which decisions require a full MDM and which can be made by specific members who are directly involved in the case. For example, the restricted "core MDM" would not involve specialists whose expertise was not required (e.g., pathologists would not be called upon when there are no new tissue samples and clinical oncologists would be involved if the decision related to changes in systemic therapies).

The MDM should also approve or modify decisions (e.g. by requesting further tests) that were not taken by its own team who will, in the final analysis, be responsible for the outcomes. No straightforward solutions may be proposed, and each decision requires a lot of attention and individual discussion, involving the most experienced members of the MDM.

3.3.2. Communicating MDM decisions to patients

Patient communication is fundamental in care delivery and should be done in a timely manner to allow for appropriate further investigation or treatment, if required, and to minimize patient anxiety, even if they are discharged with no further action required. Since not all communication needs to be person-to-person to be efficient and effective, we recommend a streamlined approach:

1. cancer diagnosis and treatment plan should be communicated by a clinician, supported by the breast care nurse, in a face-to-face appointment;
2. following a confirmed diagnosis of breast cancer, discussion of further investigation results and management plans may be communicated by a clinician in a telephone consultation, followed by written confirmation and a face-to-face appointment after the next step of investigation/management has been completed;
3. breast lesions with uncertain malignant potential (also known as B3 or "high-risk" lesions) should be communicated by a clinician, supported by the breast care nurse, in a face-to-face appointment;
4. complex benign lesions, e.g., large or volume increasing fibroadenoma should be communicated by a clinician, supported by the breast care nurse, in a face-to-face appointment;
5. benign lesions may be communicated by telephone followed by written confirmation.

3.3.3. MDM as a training resource

Multidisciplinary working is standard clinical practice which is found in many training programmes, particularly in cancer care. The INTERACT-EUROPE 100, a project coordinated by European Cancer Organization (ECO) [11] and co-funded by the European Union, is a good example of a training programme that provides cancer care professionals with the tools to improve inter-disciplinary collaboration, thus facilitating clear understanding of roles and competencies.

Training should be integrated into the MDM setup. Strategies to ensure that trainees of all specialties dealing with breast care are involved in it include suitable resource provision (e.g., time allocation, duty roster, supervision and support).

Depending on how under- and post-graduate education and training are organized in different countries, appropriate funding should be provided for the following type of scenarios for trainees:

1. undergraduates in medicine or allied health professional disciplines (e.g. psycho-oncology, physiotherapy, nursing) should observe MDMs as part of their curriculum, with briefing and de-briefing provided before and after.
2. postgraduate trainees in core MDM disciplines (e.g. surgery, radiology, pathology, medical and radiation oncology) should participate in MDM in a step-wise and competency-based fashion to observe, present cases (under supervision); lead discussion and propose outcome under direct supervision (core member present); lead discussion and propose outcomes under indirect supervision (core member on-call).

3.3.4. MDM costs and reimbursement

Preparation of and participation in MDMs involves labour costs, particularly for core departments such as pathology, radiology and oncology. The high-quality preparation that is required for maximal MDM efficiency is a time-consuming administrative burden that is often best facilitated by trained, motivated support staff, thus freeing clinicians to continue direct patient care.

As MDMs improve quality of care, are associated with fewer medical errors and better cancer outcomes, health system administration should provide financial support and assign professional and secretarial staff for MDM preparation, bearing in mind that MDM stakeholders include patients' advocacy groups, healthcare providers, national healthcare system representatives, institutions, insurance companies.

4. Discussion

Present EUSOMA recommendations for MDM optimization were developed by a group of international experts in BC and are the outcomes of online discussions, shared documents, etc. The survey results were as expected for the EUSOMA certified European centres [12],as they adhere to EUSOMA recommendations [2]. Although some differences emerged with non-EU Breast Centres, the results derived from large BC Centres in various countries, which may not represent routine practice there. The main limitation of the survey was the low response rate of non-EU breast centres which was 34 % compared with 98 % EUSOMA centres.

Concurring with other observations [13], EUSOMA envisaged the chairperson's role as crucial to successful MDM organization and workflow. The chairperson should have the leadership, managerial, intellectual, and emotional skills to ensure team cohesion and patient-centered care so that physicians and patients benefit from the MDM. A good chairperson was defined as "someone who doesn't talk too much, who lets others talk and who invites opinions from those who don't speak up" [13]. The chairperson may rotate among MDM members. Indeed, BC teams in the UK [14] found that the most effective outcomes derived from teams that shared the leadership role for clinical decision-making in the form of "plural, democratic, or distributed leadership" [10].

Although MDM preparation and conduction are time-consuming and labour-intensive, not all this work needs to be done by clinicians. Indeed, recommendations for optimizing MDM propose "Gathering information and presenting cases can be assigned to one of several team members, including residents, fellows or trainees [7], or others (e.g., BC nurses, administrators, coordinators, data managers)."

Even though MDM costs are another major issue, few studies took them into account when assessing the pros and cons of MDMs. In the Royal Marsden Hospital trust (UK), MDM cost per month was calculated to range from £2,192 to £10,050 (median £5,136) with all 14 MDM costing in total £80,850, at a cost of £415 for each new patient [1]. Extrapolating these data to annual costs suggests this hospital spends £970,296 per year on solid tumours and lymphoma MDMs, i.e. approximately the equivalent of the annual NHS salaries of 50 nurses or 20 consultants. Consequently, although hospital management should commit to allotting resources for MDMs, innovative modalities are urgently needed to reduce their time, labour and costs, so as to keep them sustainable. For example, three core MDM members might preselect "straight-forward" cases which would not be discussed during the main MDM. Furthermore, use of checklists and templates will shorten discussion times while in the future algorithms and artificial intelligence may be considered. Everyone involved in MDMs together with hospital administrators need to establish the most effective and reasonable way to share the workload and costs.

Time dedicated to MDMs is a critical issue. In the present survey, a weekly MDM lasting for 1−2 h seemed to be the favourite format. A UK review reported that each clinical case usually received less than 2 min discussion [15] while Australian data indicate 5−8 min [16]. For patients with distant metastases, 5−10 min have been proposed [5], depending on case complexity. Overall, MDM must be implemented for metastatic cases. Indeed, although an EUSOMA document stated that at least 50 % of metastatic cases must be discussed [2], 47 % of EUSOMA and 44 % of non-EU MDM discussed between 50 and 99 % of cases. Under 50 % of cases were discussed in 26 % of the EUSOMA MDMs and in 50 % of non-EU MDMs.

Concerns remain for BC cases that are managed outside of BC centres where MDMs are not structured or even held. Health professionals working there should be made aware of the benefits and impact of MDM in defining the best treatment strategy for each patient.

One future aid may lie in EUSOMA development of standard MDM templates as guides. We can envisage separate electronic templates for the following diseases and stages:

1. primary BC;
2. loco-regional recurrent or secondary BC;
3. metastatic BC at first diagnosis;
4. metastatic BC at follow-up;
5. other breast malignancies (e.g., sarcomas, lymphomas or metastases from non - BCs).

5. Conclusions

The benefits of MDM include fostering a cohesive team, shared decision-making, increasing patient enrollment in clinical trials. MDMs are educational not only for trainees, but for all team members. These EUSOMA recommendations were designed to support breast centres in improving and standardizing MDM organization and management so as to ensure each patient receives the most appropriate, tailored, guideline-aligned treatment.

An increasing number of BC patients combined with staff shortages signifies that new solutions and tools are required to streamline workloads and continue optimal patient care. The pace at which new solutions will be implemented may differ in centres and settings, depending on the available financing, skills and competences.

CRediT authorship contribution statement

G. Curigliano: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **L. Marotti:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **C. Barrios:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **N.M.L. Battisti:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **K.L. Cheung:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **S. Chia:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **S.L. Graff:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **O.J. Hartmann:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **I. Rubio:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **D. Santini:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **F. Sardanelli:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **E. Senkus:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **P. van Dam:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **M. Walker:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **J. Wu:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **C. Aristei:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation, Conceptualization.

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References

[1] De Ieso PB, Coward JI, Letsa I, et al. A study of the decision outcomes and financial costs of multidisciplinary team meetings (MDMs) in oncology. Br J Cancer 2013; 109:2295–300. https://doi.org/10.1038/bjc.2013.586.
[2] Biganzoli L, Cardoso F, Beishon M, et al. The requirements of a specialist breast centre. Breast 2020;51:65–84.
[3] Shao J, Rodrigues M, Corter AL, et al. Multidisciplinary care of breast cancer patients: a scoping review of multidisciplinary styles, processes, and outcomes. Curr Oncol 2019 Jun;26(3):e385–97. https://doi.org/10.3747/co.26.4713. Epub 2019 Jun 1.PMID: 31285683.
[4] Huang RS, Mihalache A, Nafees A, et al. The impact of multidisciplinary cancer conferences on overall survival: a meta-analysis. J Natl Cancer Inst 2024 Mar 7;116 (3):356–69. https://doi.org/10.1093/jnci/djad268. PMID: 38123515.
[5] Merker L, Conroy S, El-Wakeel H, et al. Streamlining the multi-disciplinary team meeting: the introduction of robust pre-preparation methods and its effect on the length of case discussions. Multidiscip Healthc 2023 Mar 4;16:613–22. https://doi.org/10.2147/JMDH.S387174. eCollection 2023.PMID: 36910017.
[6] CH Davis, J Ho, R Stephenson, et al, Virtual tumor board increases provider attendance and case presentations JCO Oncol Pract, Vol 18 issue 10: e1603-e1609 https://doi.org/10.1200/OP.22.00158.
[7] Kočo L, Siebers CCN, Schlooz M, et al. Mapping current organizational structure and improvement points of breast cancer multidisciplinary team meetings – an interview. Study Journal of Multidisciplinary Healthcare 2022;15:2421–30. https://doi.org/10.2147/JMDH.S380293.
[8] Pons-Tostivint E, Daubisse-Marliac L, Grosclaude P, et al. Multidisciplinary team meeting and EUSOMA quality indicators in breast cancer care: a French regional multicenter study breast, vol. 46; 2019 Aug. p. 170–7. https://doi.org/10.1016/j.breast.2019.06.001. Epub 2019 Jun 7.
[9] Sassé B, Shaya S, Nimmo J, et al. Evaluating the impact of a tertiary multidisciplinary meeting in metastatic breast cancer: a prospective study breast, vol. 79; 2025, 103861. https://doi.org/10.1016/j.breast.2024.103861. Epub 2024 Dec 15.
[10] National Breast and Ovarian Cancer Centre. Multidiscilinary meetings for cancer care, A guide for health service providers. National Breast Cencer Centre; 2005. www.nbocc.org.au.
[11] https://www.europeancancer.org/eu-projects/impact/interact-europe-100.
[12] www.breastcentrescertification.com].
[13] Fradgley EA, Booth K, Paul C, et al. Facilitating high quality cancer care: a qualitative study of Australian chairpersons' perspectives on multidisciplinary team meetings. Multidiscip Healthc 2021 Dec 16;14:3429–39. https://doi.org/10.2147/JMDH.S332972. eCollection 2021.PMID: 34938082.
[14] Haward R, Amir Z, Borrill C, et al. Breast cancer teams: the impact of constitution, new cancer workload, and methods of operation on their effectiveness. Br J Cancer 2003;89(1):15–22. https://doi.org/10.1038/sj.bjc.6601073.
[15] Soukup T, Lamb BW, Weigl M, et al. An integrated literature review of time-on-task effects with a pragmatic framework for understanding and improving decision-making in multidisciplinary oncology team meetings. Front Psychol 2019;10:1245. https://doi.org/10.3389/fpsyg.2019.01245.eCollection2019.
[16] Rankin NM, Lai M, Miller D, et al. Cancer multidisciplinary team meetings in practice: results from a multi-institutional quantitative survey and implications for policy change. Asia Pac J Clin Oncol 2018;14(1):74–83. https://doi.org/10.3389/fpsyg.2019.01245.eCollection2019.