



Defining the role and competencies of the medical oncologist in diagnostic and therapeutic care pathways: Consensus recommendations from the Italian association of medical oncology (AIOM)

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Abbreviations: Pts, patients; DTCP, diagnostic and therapeutic care pathway; EPA, European Pathway Association; AIOM, Italian Association of Medical Oncology; MOG, multidisciplinary oncology group; GPP, Good Practice Point; ASL, Local Health Center in Italy; GP, general practitioner; INPS, National Social Insurance Agency in Italy; ADO, integrated home care in Italy; CGA, Comprehensive Geriatric Assessment.

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ABSTRACT

Background: Diagnostic and Therapeutic Care Pathways (DTCPs) are clinical governance tools aimed at managing the care of specific patient populations through the coordinated application of standardized, evidence-based interventions by multidisciplinary teams. Their primary goal is to ensure equitable, timely, and cost-effective access to high-quality care.

Materials and method: A panel of recognized opinion leaders, endorsed by the Italian Association of Medical Oncology (AIOM), was convened to develop a consensus document defining the role of the medical oncologist within Multidisciplinary Oncology Groups (MOGs) and DTCPs. Employing the RAND/UCLA Appropriateness Method in its "consensus conference" format, the panel evaluated a series of statements derived from a review of the scientific literature and expert-generated Good Practice Points (GPPs). These statements addressed five key areas.

1. Skills of the Oncologist in the diagnostic phase
2. Follow up
3. Palliative care
4. Management of the diagnostic and therapeutic care pathway of the oncological patient
5. Medical therapy.

To further support each topic, illustrative case studies were presented.

Results: A total of 21 articles met the inclusion criteria, yielding 88 evidence-based recommendations. Additionally, panel members contributed 9 further GPPs based on clinical expertise. Of the 97 total recommendations, 95 received a relevance score above 7, while 2 scored between 4 and 6.9; none scored below 4.

Conclusions: This consensus effort and the resulting document represent a comprehensive evaluation of the available evidence regarding the role of medical oncologists within MOGs and DTCPs. The objective is to propose standardized criteria for the optimal management of cancer patients (pts) across all phases of care from initial diagnosis and staging to treatment, follow-up, and end-of-life support.

1. Introduction

It is now widely recognized that cancer patients (pts) should be effectively managed and constantly reassured from the moment they enter the care system. This process should be guided by formalized and shared rules and procedures to ensure consistency and quality. The most appropriate treatment pathway must be identified and tailored not only to the specific neoplasm but also to the individual characteristics and needs of each patient [1].

With this aim, diagnostic and therapeutic care pathways (DTCPs) were developed. These pathways serve as essential tools for designing and structuring care processes that are centered on pts' needs, thereby enhancing the quality of care. DTCPs are now defined as complex interventions that support shared decision-making and coordinated care for defined patient populations over specific timeframes. Their goal is to improve the quality of care across the continuum of care, improving patient outcomes, increasing safety and satisfaction and more efficient use of healthcare resources. Key elements of DTCPs include:

- the clear explanation of the objectives and key elements of care, based on scientific evidence, best practices, characteristics and expectations of pts;
- facilitating communication between members of the multidisciplinary and multi-professional team, pts and their families;
- the organization of the care process through the coordination of roles, and the sequential implementation of the activities of multidisciplinary care teams, pts and their families;
- documentation, monitoring and evaluation of outcomes (clinical health outcomes) and any deviations from the established appropriateness standards;
- identification of resources appropriate to their implementation.

Within a clinical network the development and implementation of DTCPs for major diseases support the development of interdisciplinary care plans grounded in scientific evidence and best clinical practices. These pathways are designed for specific patient groups over defined timeframes and promote coordinated interventions following a documented sequence of care [2]. By following a DTCP, pts receive the most effective and safest treatments at the appropriate time, with particular

attention not only to clinical management but also to relational and communication aspects of care.

The European Pathway Association (EPA) has long distinguished DTCPs into two categories: Model Pathway and Operational Pathway [3]. The former relates to DTCPs characterized by a supra-organizational (regional/national/international) perspective that is not organization-specific, while the latter relates to the actual representation of pathways at the local level based on available resources and expertise. As a logical consequence, it follows that Model Pathways are used as a platform on which Operational Pathways are later implemented at local level.

The DTCP serves as a model for contextualizing clinical guidelines within the specific healthcare organization of a given territory or region, considering available resources and ensuring the provision of Essential Levels of Care. The systematic adoption of a DTCP should, therefore, be aligned with the organizational structures of hospital networks—such as the Hub & Spoke model—or with the evolving models of oncology care, including Comprehensive Cancer Centers and integrated cancer networks. Additionally, DTCPs must reflect the structured relationships between hospital-based and community-based services to guarantee true continuity of care.

Quality indicators are essential tools for measuring the standard of care delivered within a DTCP using readily available data. These indicators are typically classified into two categories: outcome indicators, which assess the effectiveness of disease management, and process indicators, which evaluate the appropriateness of clinical actions taken. When used alongside audit processes, quality indicators for a specific pathology provide a robust framework for monitoring adherence to clinical guidelines and identifying areas for improvement.

For each indicator, both a minimum acceptable threshold and a target goal should be defined. For indicators that do not meet the expected standard, the multidisciplinary team is responsible for identifying and agreeing upon corrective actions aimed at improving clinical performance. The indicators should be aligned with the various stages of the patient's diagnostic-clinical process [4].

In this context, the Italian Association of Medical Oncology (AIOM) has established a working group composed of expert healthcare professionals to assess the scientific evidence regarding the role of the medical oncologist within Multidisciplinary Oncology Groups (MOGs) and DTCPs. This work has been carried out using the "consensus conference" methodology, with the goal of developing evidence-based recommendations to support healthcare professionals in clinical practice.

2. Materials and methods

A modified version of Delphi methodology by RAND/ UCLA [5] developed by the working group has been employed as a consensus tool among participants. The original Delphi tool is a quick and structured method for obtaining opinions on a specific topic by a group of experts constituting the evaluation panel.

The members of the panel evaluated a series of statements, partly from the scientific literature and partly formulated by the experts themselves, through several rounds where each round is defined based on the feedback of the previous evaluation.

The participants made a judgment of relevance on a scale from 1 to 9. At the end of this phase a ranking was produced, and a second meeting was scheduled to discuss the uncertain claims classified with a median score in the range of 4–6.

2.1. Participants and recruitment

A group of opinion leaders from academic and institutional backgrounds related to the discipline of Oncology was involved with the aim to identify the most effective interventions on the role of the Oncologist within the MOGs and DTCPs and propose specific strategies for their application in the management of cancer pts.

A methodological support group was expected to conduct the collection of information and process the data.

2.2. Literature research

The search strategy involved seeking primary and secondary studies to describe the most robust scientific evidence on the topic.

The bibliographical research of scientific documents was carried out by searching the main biomedical database (Pubmed/Medline) through keywords/MESH terms.

Studies published from 1/1/2000–28/02/2022 were reviewed.

2.2.1. Criteria for selection/inclusion of documents

A - Eligibility: All scientific documents concerning the production of good practices in the development of care settings have been considered eligible for inclusion.

B - Selection of eligible documents: The following selection/inclusion criteria were used for the selection of studies:

- studies in English or Italian;
- studies on healthy adults and adults with cancer;
- search for evidence from 1/1/2000 al 28/02/2022;
- relevance of the study for the reference context.

All the following evidence was excluded:

- not in English or not in Italian;
- published before 1/1/2020 and after 28/02/2022;
- referred to the pediatric population;
- referred to pts with non-oncological or hematological diseases;
- related to studies not relevant to the topic.

2.2.2. Evidence report

Through the creation of an evidence report for each selected study, the following information was reported:

- reference and country;
- introduction;
- materials and methods;
- results and conclusions.

2.3. Statements selection

Two independent authors conducted a detailed review of the selected papers. They both extracted key evidence in the form of statements or expert opinions from the documents. Following a comparison of their selections, a list of statements was structured in an excel matrix, accompanied by a minimum dataset that included bibliographic references along with authors of the paper, title, journal, year of publication and country where the study was conducted.

Furthermore, the following topics were identified:

1. **Skills of the Oncologist in the diagnostic phase**
2. **Follow up**
3. **Palliative care**
4. **Management of the diagnostic and therapeutic care pathway of the oncological patient**
5. **Medical therapy.**

Finally, the panel received the Excel matrix by e-mail.

Relevance evaluation of the statements selected by the literature, additional recommendations and case studies

The members of the panel evaluated the relevance of each statement.

A modified version of the Delphi methodology has been used for the evaluation: specifically, the panel members evaluated the relevance of good practices selected as follows:

1. **First evaluation of relevance:** individual assessment by each group member for each statement proposed within specific subgroups. The judgment was expressed on a scale from 1 to 9, where 1 = certainly irrelevant, 9 = certainly relevant and 5 = uncertain.
2. **Second evaluation of relevance** (with the possibility of group comparison): evaluation of intermediate judgments (band 4–6.9). Participants displayed a report showing the results of the first evaluation for each recommendation. The discussion then focused on any potential areas of disagreement.
3. **Data analysis:** the scenarios were judged in agreement in which the remaining judgments fell into any of the three regions of the score (1–3, 4–6, and 7–9), corresponding to the three levels of evaluation.

In addition to the compilation of the matrix according to the above criteria, participants were asked to provide additional recommendations to be referred to as Good Practice Points (GPPs), attributed to five pre-defined topics (see above), and then submit them to the Panel. The recommendations have been included in the set of statements to be voted on following the first evaluation (Fig. 1).

Finally, in support of each specific topic addressed, the group deemed it appropriate to present some successful case studies. Based on the average evaluation of the various recommendations, these were then included in the final document.

3. Results

Based on the review and analysis of the available literature, 21 articles met the inclusion criteria for the selected time period (Fig. 2), from which 88 relevant statements were extracted. Panel participants were also given the opportunity to contribute additional recommendations not directly derived from the literature, such as GPPs, resulting in 9 further contributions. Following a relevance assessment by the expert panel, 95 recommendations received a score higher than 7, 2 were rated between 4 and 6.9, and none scored below 4 (Tables 1–5).

1. Skills of the Oncologist in the diagnostic phase
2. Management of the diagnostic and therapeutic care pathway of the oncological patient

4. Discussion and conclusions

The Oncologist plays a pivotal role in the care of cancer pts, starting from the moment of the diagnostic suspicion and/or diagnosis and continuing throughout the course of the disease. The Oncologist is responsible for identifying and overseeing the most appropriate diagnostic and therapeutic strategies, during the entire clinical history of the patient. This requires close collaboration with other specialists within a multidisciplinary framework and the application of effective communication strategies.

The Oncologist has the task of deepening the suspected diagnostic findings, to determine the stage and severity of cancer, and subsequently planning the most appropriate treatment based on these insights as well as the patient's overall health status (e.g., age, comorbidities). In this context, the tumor biopsy is a crucial step for the oncologist, as it provides essential information for formulating a valid and targeted therapeutic approach. Without this in-depth analysis of the neoplasm, it is impossible to develop a potentially effective treatment plan.

The Oncologist should have competence about the drugs, indications, administration methods and potential short- and long-term side effects, including strategies for their prevention and management. The therapeutic approach during the active treatment phase should be adapted based on a comprehensive global assessment of the patient. Additionally, the oncologist should understand the timing of systemic therapies – whether concurrent or sequential – and how they interact with other treatment modalities. It is crucial to be aware of potential pharmacological interactions between anticancer treatments and any

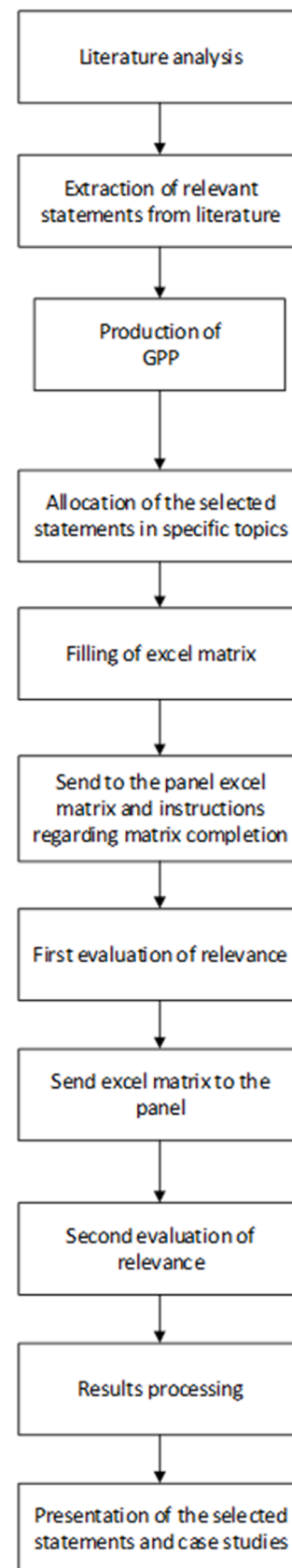


Fig. 1. The modified version of Delphi methodology by RAND UCLA developed by the working group.

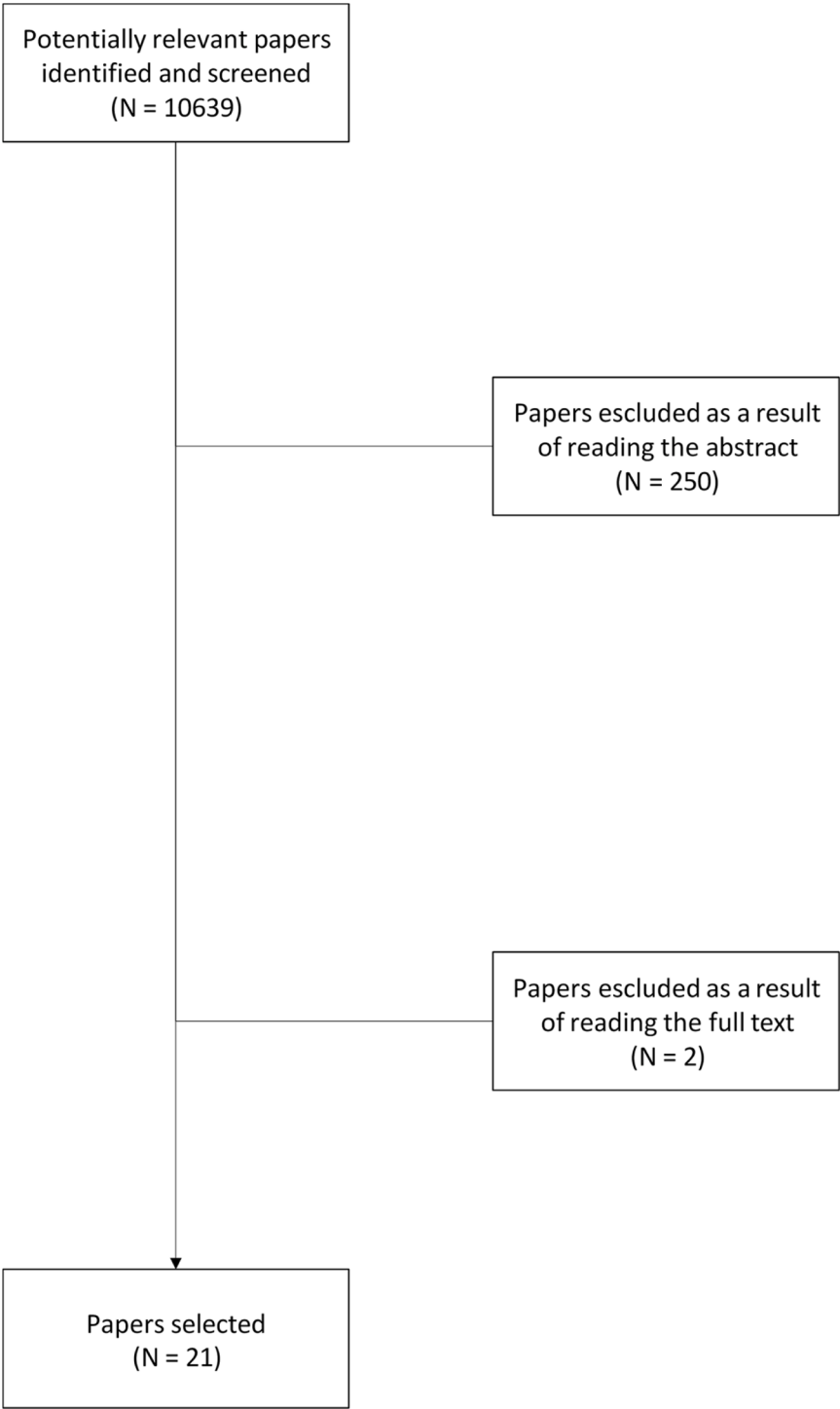


Fig. 2. Algorithm of selected papers.

other medications taken by the patient, and to address these issues in a multidisciplinary context. Furthermore, a clear policy should be in place for documenting the qualifications of the staff responsible for ordering, preparing and administering chemotherapy, as well as for obtaining informed consent of the pts regarding their DTCP.

For disease-free pts the Oncologist’s role remains central in the follow-up phase during the first five years following diagnosis. In this phase, the Oncologist coordinates care among other healthcare professionals for the overall well-being of the patient discouraging unnecessary multi-specialist follow-up. In this regard, it should be emphasized that the Oncologist is not responsible for prescribing diagnostic tests for

unrelated pathologies, which falls under the purview of the general practitioner or other specialists.

Conversely, in cases of pts with incurable diseases, the Oncology Unit should have expertise in Palliative Care and the presence of an Oncologist who is expert in Palliative Care and plays an interface between the oncology team and the palliative care service, whether it is located within the hospital or in the community.

To our knowledge, this represents the first document to be produced through the “consensus conference” method, providing recommendations on the role of the Oncologist in the MOGs and DTCPs. These expert-driven recommendations provide a shared foundation and set high

Table 1

Recommendations on the theme “skills of the oncologist in the diagnostic phase” with relevance assessment.

Statements	Assessment
While taking charge of the patient with incurable metastatic cancer, the patient should be given information on the diagnosis and curability of the tumor. This requires adequate communication strategies which should be acquired by the medical Oncologist in their training path to be able to face the objectives of treatment and the prognosis of the disease with the patient in a realistic way [6].	9
The Oncologist should know the imaging methods (ultrasound, CT, PET, MRI) to be required according to the context and clinical question [7].	9
The Oncologist should be able to read and interpret pathological reports explaining their meaning and implications to the patient ⁷ .	9
The Oncologist should know the mechanisms and pathophysiology of the most common symptoms observed in the patient with advanced cancer ⁷ .	9
The Oncologist prescribes diagnostic investigations of relevance [8].	9
The Oncologist evaluates the oncological indication and therapeutic approach ⁸ .	9
Through the clinical examination, interview and analysis of any examinations brought by the patient, the Oncologist will have to prepare the next diagnostic care pathway (furthermore detailed examinations, evaluation from the multidisciplinary team, ...) [9].	9
The communication training aimed at pts could encourage their active participation during the interview with the Oncologist: show empathy, use open questions [10].	8
The Oncologist should be able to interpret radiological images and discuss them within multidisciplinary groups ⁷ .	8
Through the clinical examination, interview and analysis of any examinations brought by the patient, the Oncologist will have to prepare the next diagnostic care pathway (further detailed examinations, evaluation from the multidisciplinary team, ...) for all neoplasms.	8
The specialist of the hospital ward who oversees the patient and who has planned the care pathway monitors the progress of the diagnostic process and assumes the task to formulate the clinical summary of the information collected at the end of the diagnostic process [11].	8
The Oncologist prescribes diagnostic investigations of relevance for all disease types.	4

Statements without a bibliographic reference are GPPs

2. Follow-up

standards that can be applied in everyday clinical practice to enhance the quality of care for cancer pts. This methodology could be applied across all areas of medicine, replicating our approach with the involvement of specific experts.

However, this work does have some limitations. First, the panel selection process was not entirely systematic, despite efforts to choose members based on their specific expertise in the field and the complementary nature of their knowledge. Furthermore, the inherent subjectivity of those involved in selecting the literature and identifying relevant statements has inevitably influenced the results.

In conclusion, this document represents an effort to assess the available scientific evidence on the role of the Oncologist in the MOGs and DTCPs and to suggest standardized criteria for the optimal management of cancer pts—from diagnosis to treatment, follow-up, and end-of-life care.

CRediT authorship contribution statement

Michele De Tursi: Writing – review & editing, Data curation. **Angelo Dinota:** Writing – review & editing, Data curation. **Antonella Brunello:** Writing – review & editing, Data curation. **Marcello Tucci:** Writing – review & editing, Data curation. **Rossana Berardi:** Writing – review & editing, Writing – original draft, Supervision, Data curation, Conceptualization. **Filippo Pietrantonio:** Writing – review & editing, Data curation. **Francesca Rossi:** Writing – original draft, Investigation, Data curation, Conceptualization. **Roberto Papa:** Writing – review & editing, Data curation. **Ugo De Giorgi:** Writing – review & editing, Data

Table 2

Recommendations on the theme “Follow-up” with relevance assessment.

Statements	Assessment
At the end of the acute phase of treatment, the Oncologist should provide pts with no evidence of disease with precise indications on screening and prevention of other cancers, prevention of late effects of therapies and rehabilitation not only physical, but also cognitive, psychological, nutritional and sexual, for a return to an active life [12].	9
It is desirable to automate the procedure of activation (and possible renewal at the end) of the exemption for oncological diagnosis (048) by providing that the healthcare professional/ healthcare facility that certifies for the first time the oncological diagnosis send to the competent Local Health Center (in Italy ASL) the related certificate, so as to avoid bureaucratic steps at the expense of the patient or caregiver ¹² .	9
In case of recurrence, the patient will be appropriately re-evaluated by the Oncologist to define the most appropriate DTCP according to the most updated guidelines [13].	9
On the organizational level, the Oncologist should determine the moment management transition should take place and, at the same time, they should identify the coordinator of the subsequent phases, General Practitioner (GP) or Oncologist [14].	8
The Oncologist should plan a categorization of pts that considers the natural history of the disease, the personal medical history of each patient, including family history and genetic mutations, environmental exposures and other risk factors, family and socio-cultural context and available economic resources [15].	8
Follow-up data should be part of the DTCP data that will be used for periodic audits ¹² .	8
Measures to facilitate social integration and return to work, including initial assessment and adaptation of working conditions for cancer pts, should be an integral part of the patient care pathway ¹² .	8
It is important to promote training on the use of National Social Insurance Agency (in Italy INPS) certificate for Oncologists to avoid critical issues related to its correct compilation and the very low adherence of specialists with consequent delays in the oncological disability assessment procedure ¹² .	8
It is necessary to overcome the obstacle related to the assessment of oncological disability in the facilities in which the treatment is carried out and the presence of the specialist in Oncology in the Medical Committees ¹² .	8
The Oncologist should plan the follow-up with the GP according to individual care programs (survivorship care plans) and use tools for recording visits and circulation of clinical information (electronic medical record) [16].	8
The Oncologist is the coordinator of the other specialists for the overall well-being of the patient and not only for the detection of relapse.	8
The Oncologist should discourage multi-specialistic follow-up: risk of overlapping visits and examinations from part of the specialists who contributed to the diagnostic phase and initial treatment [17].	8
The Oncologist ensures follow-up until the fifth year from the diagnosis ¹⁷ .	8
The GP is the referent for the patient and the coordinator of the other specialists for the overall well-being of the patient and not only for the detection of relapse [18].	7
The Oncologist ensures follow-up over five years from the diagnosis ¹⁷ .	4

Statements without a bibliographic reference are GPPs

3. Palliative care

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Table 3

Recommendations on the theme “Palliative care” with relevance assessment.

Statements	Assessment
A shared procedure of patient assessment for the access to the Palliative Care team should be available in every Oncology and Radiotherapy Unit; the Palliative Care team should participate in multidisciplinary meetings and be involved in DTCPs of all types of cancer. It is also important a written procedure with process and outcome indicators ¹² .	9
A basic level of expertise in Palliative Care should be the cultural heritage of all doctors who treat the cancer patient [19].	9
In the Hospital Unit of Oncology, it is desirable the presence of a widespread competence in Palliative Care and the presence of an Oncologist who is expert in Palliative Care and plays an interface role with the Palliative Care Service/Unit (where present in the Hospital or in the territory to which it belongs) [20].	9
The Oncologist is required a specific training in palliative medicine that should be an integral part of his curriculum ²⁰ .	8
If a Palliative Care Unit is not present in the hospital department, it is desirable that in each Hospital Unit of Oncology there are one or more doctors dedicated to the clinical management of such situations ¹⁹ .	8
The Oncologist initiates the patient to Palliative Care supported by other specialists in need [21].	8
In order to guarantee the appropriate Palliative Care to terminal pts no longer manageable within an integrated home care program for cancer patient (ADO), or for whom the hospitalization is no longer appropriate, it is planned the temporarily or permanently hospitalization of the patient in Hospices or Pain Therapy and Palliative Care Units already present on the regional territory or in construction if requested by the Oncologist, the patient himself or his caregiver ¹³ .	8

Data curation. **Francesco Carrozza**: Writing – review & editing, Data curation. **Rita Chiari**: Writing – review & editing, Data curation. **Roberto Bianco**: Writing – review & editing, Data curation. **Matteo Lambertini**: Writing – review & editing, Data curation. **Francesco Leonardi**: Writing – review & editing, Data curation. **Giuseppe Curi-gliano**: Writing – review & editing, Data curation. **Alessandra Bearz**: Writing – review & editing, Data curation. **Saverio Cinieri**: Writing – review & editing, Data curation. **Alessandra Fabi**: Writing – review & editing, Data curation. **Lorena Incorvaia**: Writing – review & editing, Data curation. **Giovanni Micallo**: Writing – review & editing, Data curation. **Antonio Russo**: Writing – review & editing, Data curation. **Giancarlo Di Pinto**: Writing – review & editing, Data curation.

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Rossana Berardi reports financial interests (grants): Bayer, Advisory Board, Personal; Boeringher Ingelheim, Advisory Board, Personal; Eisai, Advisory Board, Personal; Lilly, Advisory Board, Personal; Menarini, Advisory Board, Personal; GSK, Advisory Board, Personal; No financial interests (to the Institution): AstraZeneca, Funding, Institutional; Pfizer, Funding, Institutional; Roche, Funding, Institutional. Alessandra Bearz reports

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Table 4

Recommendations on the theme “Management of the diagnostic and therapeutic care pathway of the oncological patient” with relevance assessment.

Statements	Assessment
Every Hospital Unit of Oncology and Radiotherapy, and every other Hospital Unit involved in delivering services to cancer pts, should have a company procedure that clearly identifies roles, accountability, modalities and timing of performance, with detectable and measurable process and outcome indicators ¹² .	9
On the organizational level, it is desirable to create a dedicated care pathway to "unscheduled accesses" that can affect pts treated at the Hospital Unit of Oncology and with not deferrable clinical needs after nursing assessment (triage) carried out by suitably trained personnel. The involvement of a nursing staff (Oncology Nurse Navigator or Nurse Case Managers in Oncology in close connection with family and community nurses and the hospital) ensures continuity, quality and appropriateness of care for cancer pts, for example for home monitoring of possible toxicity of oncological treatments ¹² .	9
It is essential and strategic to invest in computer and electronic media (electronic medical record, electronic health record) that allow a direct communication in real time and even at a distance between different professionals who treat the same cancer patient in continuity or at different stages of the disease ¹² .	9
The management of the service offer could benefit from a regulation through electronic agendas governed by Booking Centers and/or directly by the professionals involved. In this regard, for an adequate management of the waiting lists it would be necessary to ensure four aspects. 1) Transparency: the service offer and average waiting times should be transparent for all stakeholders; 2) priority levels: managing the booking in a "priority class" established by the specialist who takes care of the patient should allow a differentiated access to services by clinical priority and/or urgency to all pts who actually need them within a reasonable time on the basis of specific clinical conditions; 3) separation of channels for the different types of access: ensuring reservation systems based on priority criteria for first access, also directly usable by the prescribing physicians, and the "taking charge" of the oncological patient according to the DTCP in the case of subsequent accesses with the booking of the follow-up visit by the specialist; 4) unique "language": for an effective management of the service offer a single coding and nomenclature of these services should be adopted at all territorial/regional/national levels, also in view of the electronic prescription system ¹² .	9
Within Hospital Units and Services, the Multidisciplinary Team that takes charge of pts and shares the DTCP should be identified for each type of cancer, defining for each professional figure the role and responsibilities, including the case manager ¹² .	9
The DTCPs for the different types of cancer should be implemented with written application procedures and with declared process and outcome indicators that should be detectable annually, centrally evaluated by network organizations and possibly made public at regional level. Similarly, it would be necessary to be able to detect the quality of the activities of the Multidisciplinary Groups, through the observation of specific performance indicators. The definition and selection of indicators should be based on evidence levels and should therefore be considered as a dynamic parameter to be updated based on available scientific evidence ¹² .	9
Once the patient has access to the specific DTCP, from there the multidisciplinary discussion and the management of the patient will begin to define the assistance pathway. The patient will always have a doctor and a case manager of reference and there may be other specialists involved in the various diagnostic and therapeutic stages. A nurse should also be available at the access points to gather useful information for the care plan to consider psychological-relational, social, family-related problems of the sick, and an administrative, providing for all reservations, including examinations to be carried out at other facilities and paperwork, such as procedures for ticket exemption for pathology. Other professionals may be provided for each access point such as: psycho-oncologists and social workers for the most problematic cases, in which it may be difficult to ensure the proper compliance of pts to the indicated treatments without taking charge by these operators ¹² .	9
It is essential to realize throughout the national territory the Regional Oncological Network with the identification of first and second level centers and activation of inter-company oncological	9

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Table 4 (continued)

Statements	Assessment
departments through which to ensure the delivery of all necessary services for the best care to each patient. The Oncological Network that should allow the sharing and exchange of clinical information within its professional network should therefore be equipped with a computer architecture integrated with the regional IT system to ensure interoperability between the services of the regional territorial companies ¹² .	
Every Hospital should guarantee adequate training and updating to all professionals involved in the care pathways ¹² .	9
For an adequate assistance and care of the elderly person affected by cancer, it is essential to ensure a comprehensive taking charge of the elderly cancer patient through a multidisciplinary and multidimensional approach that includes a DTCP within the regional oncological networks, specific and facilitated to access the services of diagnosis and care. This pathway should be supported by a departmental organization that ensures the coordination of oncological and geriatric assistance and care both in hospital and at territorial level ¹² .	9
It is necessary for the multidisciplinary team to identify pts to be directed towards an appropriate multidimensional assessment of fragility which should be carried out through a Comprehensive Geriatric Assessment (CGA) with the use of appropriate screening tools such as the "G8" for the elderly cancer patient and with evaluation of the complexity form for psycho-social vulnerability ¹² .	9
A structured multidisciplinary approach ("collaborative care") should be offered to all pts, as it brings benefit on the emotional state and improves outcome. Es: - better adherence to the therapeutic plan; - improving the quality of life; - pain management; - integrated welfare performance; - monitoring throughout the course of the disease ¹⁰ .	9
It is necessary to promote the provision of chemotherapy and radiotherapy services on an outpatient basis in order to lighten the load in ordinary hospitalization stations ¹⁹ .	9
Multidisciplinary teams ensure a patient-centered approach with available and understandable information on the clinical and psycho-social aspects of the care pathway, favoring clear channels of communication between the care team, patient and family members that promote engagement [22].	9
Shared databases should be available during multidisciplinary group meetings to record clinical decision-making, results and indicators, facilitating progress assessment and identification of areas of improvement ²² .	9
The multidisciplinary team aims to identify the most appropriate therapy for each individual patient and to monitor his evolution in subsequent follow-up visits ²² .	9
The important elements to consider for a multidisciplinary team to be effective are: -correct identification of team members, the presence of appropriate skills, involvement and motivation; -availability of a physical infrastructure for meetings and an appropriate technology platform for remote meetings and data and information exchange; -clear organization for meeting logistics, meeting planning and preparation, and management of post-meeting activities (e.g. reservation of services and performances); -definition of patient-centered clinical decision-making; -team governance, data collection, analysis and audit ¹² .	9
The Oncologist is involved in coordinating the governance of the care pathway ¹³ .	9
The management of the oncological patient and the prescription of the correct DTCP are carried out by specialists belonging to the pathology-specific MOG and the Oncologist is involved in coordination ¹³ .	9
In day hospital there are procedures for information on the modalities and the course of the diagnostic-therapeutic activity and the informed consent that is given by the Oncologist to the patient [23].	9
The Oncologist should contribute actively and in a respectful and conscious manner to the different skills in a multidisciplinary team in order to plan and coordinate the assistance for pts with advanced cancer and their families ⁷ .	9
The Oncologist should know and know how to use the drugs indicated in the treatment of the main symptoms, in particular pain (opioid drugs of which he should know the dose titration, the rotation and	9

Table 4 (continued)

Statements	Assessment
the conversion scales, and the adjuvant drugs). At the same time, he should know the toxicity of symptomatic drugs and be able to prescribe drugs to prevent and manage the toxicity itself ⁷ .	
All pts should be screened for social needs at the initial examination, at appropriate intervals and when clinical conditions change ¹⁰ .	8
All pts should have access to an information and support point in the ward ¹⁰ .	8
Outpatient management promotes the continuity of care between hospital and territory and integrated care, facilitating the implementation of shared multi-specialized health centers for the joint management of the cancer patient. Systemic oncological treatments (chemotherapy, immunotherapy, biological therapies, hormonal therapy) and radiotherapy, whether delivered by professional protocols or in clinical trials, should be placed in an outpatient regime throughout the country, with undoubted benefit for the patient ¹² .	8
To facilitate the care, even at home, of pts by the Hospital Unit of Oncology, it would be appropriate to use technological tools for healthcare digitization and digital devices. In addition, patient reported outcomes measures (proms), which have been shown to provide an advantage in terms of patient survival, should be used. Remote control reduces the number of hospital accesses and anticipates the detection of possible toxicity, with undoubted advantages, especially in the elderly population ¹² .	8
In line with the National Outcomes Plan, it would be desirable for each Region to identify the centers responsible for taking charge of pts for each type of cancer, based on professional skills, volume of activity (and appropriateness of interventions) and technological equipment, to guarantee equity, quality and safety to all citizens. The provision of some particularly complex services should take place in specialized centers identified by regional planning. In addition to university centers, centers for clinical research, translational cancer research, molecular diagnostics and biobank should also be identified. These centers should have the best technology necessary to respond adequately to the innovative needs of cancer treatments and research, be equipped with teleconferencing systems to be able to carry out consultations and second opinions, even at a distance ¹² .	8
Within the DTCP it is important to develop high-definition imaging and the implementation of artificial intelligence technologies to improve diagnostic accuracy, encourage the modernization of IT equipment for diagnostic imaging, nuclear medicine, interventional radiology and radiopharmaceutical therapy, and improve the organizational efficiency needed to maximize the use of equipment ¹² .	8
For the different neoplasms and in the various stages of illness, it is necessary to activate psycho-oncological pathways of prevention, treatment and rehabilitation of emotional discomfort within the medical care pathways, whether they are supportive or more specifically psychotherapeutic for the patient and his family. These aspects also assume particular importance in the new pathway of oncological care (precision oncology), increasingly personalized and accurate, that involves therapeutic approaches based on individual and specific genetic and molecular profiles of each tumor and that result in an even more specific role of psycho-oncology to respond to the broad spectrum of emotional, behavioral and relational reactions that the new therapy can determine in the patient/caregiver/family and in the treating staff ¹² .	8
As recommended by the international guidelines of psychological and psychiatric area, a specific training in Psycho-Oncology aimed at a stable presence of specialists in this discipline in the multidisciplinary groups is necessary ¹² .	8
Within the DTCP of pathology it seems essential to develop and share elements of management of nutritional support in cancer pts and promote from the first visit the inclusion of a nutritional screening as an integral part of the DTCP ¹² .	8
The rehabilitation intervention in Oncology should not be aimed at the mere recovery of the injured physical function of the patient, but should be included in a multidisciplinary care plan in which rehabilitation is conceived and organized as a contextual phase at the time of treatment, anticipating the start of the recovery of the cancer patient when the disease and therapies begin to compromise their physical functions and participation in relationship life ¹² .	8
An integrated and systemic management of chronicity also involves interventions to promote healthy behaviors (e.g. individual	8

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Table 4 (continued)

Statements	Assessment
counseling also in opportunistic contexts for the promotion of healthy lifestyles, such as smoking cessation, alcohol reduction/cessation, healthy eating, physical activity) and the activation of prevention interventions integrated in the DTCs, also considering multipathology situations, according to an integrated approach between prevention and treatment ¹² .	
At the outpatient level, the specialist together with the nurses should guarantee quality controls on the diagnostic processes and technological equipment ¹⁹ .	8
At the outpatient level, the specialist together with the nurses should properly manage waiting lists according to the severity of the disease and possible therapeutic approaches ¹⁹ .	8
In the healthcare model of the day hospital it is the specialist who formulates the diagnostic hypothesis, defines the care pathway, performs the clinical synthesis based on the reports of the investigations carried out and proposes it to the GP [24].	8
In the healthcare model of the day hospital it is the Oncologist who formulates the diagnostic hypothesis, defines the care pathway, performs the clinical synthesis based on the reports of the investigations carried out and proposes it to the GP.	8
Screening and diagnostic tests as well as therapeutic and rehabilitation procedures that do not require hospital or home treatment are carried out on an outpatient level ¹⁹ .	8
The Oncologist takes care of any emergencies/ urgencies related to the complications of treatment or disease through coded care pathways that allow the patient a rapid access to the oncological assessment and subsequent measures (outpatient visits, hospitalizations, ...) ⁸ .	8
The Oncologist takes care of any emergencies/ urgencies related to the complications of treatment or disease through coded care pathways that allow the patient a rapid access to the oncological assessment and subsequent measures (outpatient visits, hospitalizations, ...) within any oncological care pathway.	8
The Oncologist guarantees the overall care of the patient with cancer, in particular the access to outpatient and inpatient care, both ordinary and day hospital, and the planning of laboratory and instrumental tests ⁸ .	8
The Oncologist guarantees the overall care of the patient with cancer, in particular the access to outpatient and inpatient services, both ordinary and day hospital, and the planning of laboratory and instrumental tests (for all diseases).	8
The staff guarantees a dedicated emergency/urgency management service 24 h on 24, 7 days a week, through which the first contact of the patient has the possibility to consult an experienced Oncologist at any time or the opportunity to report the patient to a specialized Center [25].	8
The Oncologist should be able to evaluate and manage the psychological and existential symptoms common to cancer pts, including stress, anxiety, depression, demoralization, loss of dignity, delirium, the possibility of suicide, the death wish, requests for euthanasia or assisted suicide, anxiety resulting from early death and uncertainty about the length of one's life ⁷ .	8
The training should ensure the acquisition of a holistic vision of the patient and a relational and valuable pathway that guarantees adequate skills for the early detection and management of physical and psychological symptoms and social and spiritual needs of the cancer patient and his family ²⁰ .	8
The Oncologist compiles and manages the clinical documentation (outpatient card, medical record) ⁸ .	8
The internal organization of the multidisciplinary group establishes the appropriate forms of clinical leadership and operational coordination, identifies a single point of contact for pts and families, systematically uses comparison (benchmarking) to integrate new knowledge in a timely manner, provides resources and time for doctors and other healthcare professionals [26].	8
The Oncologist coordinates the care pathway of the oncological patient from the care phase in the hospital to the continuity of care between hospital and territory.	8
The Oncologist is in charge of the continuous supervision of the assisted person and the monitoring of the vital signs during the procedures to which it is subjected and for the duration of the performance [27].	7
The Oncologist compiles and manages the clinical documentation (outpatient card, medical record) within any care pathway.	7
The staff provides guidance for pts in follow-up and in treatment who miss or cancel scheduled visits ²⁵ .	7

Statements without a bibliographic reference are GPPs

5. Medical therapy

Table 5

Recommendations on the theme "Medical therapy" with relevance assessment.

Statements	Assessment
At least one clinical staff member who is certified for basic life support (BLS-D) is present during chemotherapy administration ²⁵ .	9
Informed consent or dissent is documented before the start of therapy ²⁵ .	9
Oral and written information should be provided to pts on: -diagnosis; -treatment objectives: treating the disease, prolonging life or reducing symptoms; -duration of treatment, mode of administration, including timing and use of medication, drug names, support if necessary, drug and food interactions, and guidance on how to manage missed drug doses; -potential long-term and short-term side effects of therapy, including those requiring immediate assistance; -symptoms or side effects requiring immediate discontinuation of oral or other self-administered treatment; -procedures for the management of drugs in the home, including the storage, safe handling and management of unused drugs; -procedures for the home handling of hazardous biological materials; -follow-up ²⁵ .	9
The Oncologist evaluates the oncological indication and therapeutic approach ⁸ .	9
The treatment setting has a policy to document the qualifications of the staff who orders, prepares and administers chemotherapy to the patient and document: -description of the initial training requirements and competences; -description of the annual (at least) continuing training requirements; -description of the certification acquisition processes (independent licensed professionals) and how certifications are documented; -description of the competence demonstration and documentation ²⁵ .	8
The care setting refers to a comprehensive educational program for the initial educational requirements for all healthcare personnel preparing and administering chemotherapy ²⁵ .	8
A doctor supports the nursing staff while administering chemotherapy ²⁵ .	8
At each subsequent visit or treatment day, staff should perform and document a patient assessment including at least the following: -performance status; -vital signs; -weight (at least once a week); -height (at least once a week); -toxicity from treatment and overall tolerance of therapy; -pain assessment scale (e.g. numerical scale) ²⁵ .	8
In the ward there are specific indications on how to obtain and document the dissent or consent to therapy ²⁵ .	8
In the ward standard protocols are followed for monitoring the response to each treatment and that define the frequency with which to perform specific laboratory and monitoring tests of organic functionality in an appropriate way ²⁵ .	8
The Oncologist evaluates the oncological indication and therapeutic approach for all pathologies.	8
The care setting policy outlines the procedure for monitoring an initial assessment of pts' adherence to chemotherapy ²⁵ .	7,5

Statements without a bibliographic reference are GPPs

Advisory/Consultancy from BMS, MSD, Amgen, Pierre-Fabre, Johnson&Johnson, Servier, Bayer, Takeda, Astellas, GSK, Daiichi-Sankyo, Pfizer, BeOne, Jazz Pharmaceuticals, Incyte, Rottapharm, Merck-Serono, Italfarmaco, Gilead, AstraZeneca, Agenus, Revolution Medicine. Travel expenses from Amgen, Merck-Serono, Pierre-Fabre, Servier, Astellas, Incyte, Johnson&Johnson.

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