Canadian Association of Radiologists
L'Association canadienne des radiologistes

CAR Recommendations for Improving Multidisciplinary Team Meetings and Processes

Board Approval: April 2026

Executive Summary

Multidisciplinary team meetings (MDTM) are a cornerstone of high-quality care in oncology and complex disease management. Radiologists play a central role in these meetings by synthesizing imaging findings, integrating clinical context, and supporting collaborative treatment decisions. However, radiologists across Canada report escalating workload pressures, administrative inefficiencies, and technological barriers that increasingly threaten the sustainability and effectiveness of these MDTMs.

Findings from a national survey demonstrate substantial variation in case submission practices, frequent late or incomplete case lists, inconsistent communication of clinical questions, limited preparation time, and widespread lack of compensation or formal recognition for MDTM participation. As a result, radiologists often prepare for MDTMs outside of regular working hours or while simultaneously managing clinical service demands, undermining both efficiency and wellbeing. These systemic challenges risk diminishing the quality and timeliness of imaging input at MDTMs, affecting patient-centered decision-making.

This position statement presents **15 consensus based recommendations** developed through a national Delphi process informed by the *CAR Survey of Patterns and Perspectives on Multidisciplinary Team Rounds in Canada*.[1] The recommendations establish minimum operational standards to improve communication, define clear submission deadlines, standardize case formats, manage case volume, and ensure adequate preparation time. They further emphasize the importance of strengthened administrative and IT support, structured facilitation of discussions, improved technological integration, and fair remuneration models that recognize MDTM participation as essential clinical work.

Together, these recommendations provide a practical national framework for radiology departments, healthcare institutions, and provincial systems to improve the efficiency and sustainability and clinical impact of MDTMs. Implementing these standards will support radiologist wellbeing, enhance interprofessional collaboration, and ensure that MDTMs continue to deliver high-quality, patient-centered care across Canadian healthcare settings.

Introduction

Multidisciplinary team meetings (MDTM) are widely considered the gold standard in complex patient management, particularly in oncology and complex chronic disease care. MDTMs provide an opportunity for various subspecialties to communicate, collaborate, and coordinate decision-making often mandatory as an expectation for oncological cases but also in the setting of complex pathology.[2–4] Multiple studies report improved clinical outcomes linked to MDTMs, often associated with enhanced treatment planning and interprofessional collaboration.[5–7] The implementation of MDTMs has demonstrated substantial benefits, yet they also present significant challenges related to communication, administrative burden, and the integration of technology. Other studies have highlighted the increasing workload for radiologists resulting from the expanding number of MDTMs and the complexity of cases over the past two decades.[8,9] There have been successful quality improvement initiatives aimed at improving the standardization and efficacy of multidisciplinary case conferences in certain Canadian institutions.[10]

This position statement unifies those findings into practical, consensus-based recommendations and minimum operational standards intended for adoption by departments and health systems. The Working Group proposes that the consensus recommendations below can be used to prompt improvements to workflows and rationalize systemic administrative processes in other hospitals and institutions.

Enhance Communication

Effective multidisciplinary team rounds rely on structured collaboration, clear communication, and adequate preparation to support high-quality, patient centered decision making. Teams need to be clear about what information is needed, and when. This section addresses persistent gaps in how cases are identified, submitted, and communicated in advance of MDT rounds.

Ask Clear Clinical Questions

Recommendation 1: Ensure that the clinical questions or goals associated with each case are clearly stated and communicated in advance. The study (or studies) in question should also be identified.

From the perspective of radiologists, whose imaging assessments often frame and guide these discussions, consistency and clarity in case selection, presentation format, and advance preparation are essential to ensuring meaningful contributions. Clearly articulating the clinical questions and goals associated with each case, and specifying the number, date, and type of imaging studies to be reviewed enable focused preparation by radiologists and more actionable imaging input. Similarly, when patients have multiple comparison examinations, identifying the most relevant studies in advance streamlines preparation and promotes efficient, clinically targeted discussion. If there is a specific imaging finding that the clinical team feels warrants discussion, providing this information in advance allows for more meaningful review.

Advance Notice for Additional Cases

Recommendation 2: Limit last-minute case additions to avoid incomplete evaluations. Any new cases should be communicated at least 48 hours before the meeting.

Establishing clear expectations for timely case submission, minimizing last minute additions, and encouraging broad multidisciplinary participation further enhances the quality, efficiency, and clinical value of MDTM's. Together, these practices strengthen shared understanding across specialties, reduce unnecessary duplication, and support collaborative decision-making that improves patient care.

A standardized and consistently enforced policy for add-on requests is strongly recommended, with at least 48 hours' notice required for new cases. Any urgent, last-minute additions should be discussed with and approved by the radiologist assigned to the meeting to ensure adequate review and maintain consistent meeting quality.

Streamline the Administrative Process

Even when clinical goals are clear, inefficient administrative processes can significantly undermine MDTM preparation and meeting flow. This section outlines operational standards to streamline case submission, enforce agreed-upon timelines, and reduce avoidable administrative burden.

Enforce Deadlines

Recommendation 3: Establish strict deadlines for case submissions to ensure timely case distribution and adequate review.

Establishing and consistently adhering to clear deadlines for case submissions is essential to ensure radiologists have adequate time to prepare for MDT rounds, particularly when cases are complex or involve external imaging review. Survey findings demonstrate that most radiologists currently receive case lists only one to two days before rounds, with over 10% receiving cases less than 24 hours in advance and only 2.3% receiving more than a week's notice.[1] To support thorough preparation and high-quality case discussion, case submissions should be received, and a finalized case list circulated, no later than three to five business days before the scheduled meeting.

Deadlines should be mutually agreed upon by radiologists and referring clinicians, balancing appropriate preparation time with the need to discuss time sensitive cases. MDT rounds with high case volumes, substantial complexity, or requests for second read reviews of external studies warrant longer lead times of at least five to seven days. Although many institutions report having cutoff policies for add-on cases, approximately one-third lack a formal policy and survey comments highlight widespread non-compliance.

Standardize Format

Recommendation 4: Implement a standardized institutional/local format for case submissions to facilitate easier review and preparation.

A standardized institutional format for case submissions is strongly advised to promote efficient review and reduce unnecessary administrative burden. Survey responses revealed that unclear clinical questions and inconsistent identification of relevant imaging studies frequently impede preparation; more than half of radiologists reported being unsure which specific study the clinical question pertained to.[1] The case submission template should include:

- Relevant patient demographics
- Pertinent medical and surgical history
- Pathology or biopsy results (if available)
- A clear and specific clinical question; (if the question pertains to a specific imaging finding that should be indicated)
- Identification of the imaging studies requiring review, (modality and examination date)

Providing this information upfront allows radiologists to focus their review on the most clinically meaningful imaging, avoiding unnecessary preparation of multiple studies and enabling more efficient, targeted discussion during MDT rounds.

Allocate Sufficient Time for Radiological Review

Recommendation 5: Aim to discuss a manageable number of cases to ensure thorough discussion and understanding, considering the intent and format of rounds.

MDTMs should be structured to support equitable and thorough discussion of each case. Across Canada, most MDTMs include six to ten cases and last 30–60 minutes, when case volumes exceed what can be meaningfully reviewed within the allotted time, the quality and efficiency of discussion are compromised. Establishing an agreed-upon maximum number of cases for radiology review, recognizing that some cases require more extensive review is integral to ensure appropriate attention to each patient and to respect the preparation time required. Case volume limits should be determined collaboratively by the core participating specialties for each set of rounds.

Case volume expectations should reflect the intent and format of the meeting. Rounds focused on rapid triage or review may accommodate a modestly higher number of straightforward cases, whereas meetings dedicated to in-depth discussion, complex oncologic decision-making, or external second-read review require smaller case lists to support high-quality, patient-centred decision-making. Adherence to these previously agreed case limits promotes timely completion of rounds, reduces deferral of decision making, and supports predictable scheduling for all MDTM participants.

Protect Preparation Time

High-quality MDTM participation requires adequate preparation time, yet current practice often relies on uncompensated or ad hoc effort by radiologists. This section sets expectations for protected preparation time as a foundational requirement for effective and sustainable MDTM participation.

Allocate Specific Hours

Recommendation 6: Designate protected time during work hours for radiologists to prepare for MDT rounds, reducing the need for after-hours work.

Adequate preparation by radiologists is essential for high quality MDTM discussions and effective patient management. However, preparation for MDT rounds is rarely embedded within formal work schedules, despite the complexity and clinical importance of this work. Current practice patterns demonstrate a significant lack of structural support for this work. Only 6.2% of radiologists reported having protected preparation time incorporated into their clinical or academic schedules, while 78.3% prepare outside regular working hours and 44.7% complete this work during clinical service amidst their other clinical duties.[1]

In the absence of protected time, preparation is frequently completed along clinical obligations or after hours. This reliance on ad hoc or unpaid effort increases cognitive load, contributes to after-hours expectations, and undermines sustainability of MDTM participation.

Institutions should therefore formally allocate protected preparation time within radiologists' regular schedules, particularly for subspecialty radiologists who are expected to lead case review or present imaging findings. Recognizing MDTM preparation as essential clinical work supports consistent participation, improves the quality of the imaging input, and promotes workforce wellbeing.

Protected time during work hours is vital to allow radiologists to adequately review complex cases, access clinical records, and prepare thoughtful contributions. Institutions and radiology groups should formally allocate this time in the weekly schedule, especially for subspecialty radiologists who are expected to lead or present at rounds. Ensuring dedicated preparation hours will enhance discussion quality, reduce the need for off-hours work, and support workforce sustainability.

Support Staffing

Recommendation 7: Increase administrative and IT support to help manage case logistics, allowing radiologists to focus on their radiological assessment.

Non-interpretive tasks associated with MDT rounds, including locating clinical details, clarifying referral questions, and managing imaging access, continue to impose substantial administrative burden on radiologists. Lack of clinical information and inconsistent communication across clinical teams lead to inefficiencies that divert time away from radiologic review and diminish the quality of MDTM preparation.

Additionally, while most institutions import external studies into PACS (68.2%), 15.5% of radiologists still perform this task themselves. 50.4% of respondents found review of images on external repositories inferior to review on their local PACS.[1]

Enhanced administrative and IT support is therefore essential. Support staff should oversee scheduling, support compliance with submission deadlines, ensure clinical questions are clearly articulated, and manage external imaging importation. While 83.7% of external studies are currently imported by support staff, this practice should be universal and expanded to include more robust assistance with data retrieval and case organization. Strengthening administrative and technical support would significantly reduce noninterpretive workload and enable radiologists to focus on the critical tasks of image assessment, integration of clinical information, and contribution to collaborative decision making.

Balance Academic and Clinical Discussions

MDT rounds serve both clinical and educational functions, but these objectives must be carefully balanced to ensure timely, actionable patient-care decisions. This section addresses the need for structured facilitation and clear norms to keep MDT discussions focused, efficient, and clinically relevant.

Facilitate Discussions

Recommendation 8: Designate a facilitator for MDT rounds to keep discussions focused and on track, preventing overly lengthy or off topic debates.

Overly broad or unfocused discussions compromise the efficiency of MDT rounds and limit the time available to address scheduled cases. Survey respondents reported that, in some settings, discussions may become prolonged or drift toward detailed appraisal of academic literature, resulting in delayed or deferred patient-management decisions.[1]

The designation of a facilitator provides a governance mechanism to support effective meeting performance. The facilitator's role is to manage time, maintain adherence to the agenda, and ensure that discussions progress toward clinically actionable conclusions. Facilitators should be empowered to summarize key points, redirect discussion when necessary, and close discussion once consensus or a clear plan has been reached.

To support consistency and continuity, the facilitator role should be clearly defined and supported by a terms-of-reference document outlining expectations, decision-making authority, and operational rules (e.g. case volume limits, submission deadlines, and policies for late additions). This structure formalizes accountability for meeting flow while enabling multidisciplinary participation.

Focus on Clinical Utility

Recommendation 9: Foster a shared culture within MDT rounds that prioritizes clinically relevant, patient-focused discussion while preserving appropriate educational value.

MDT rounds are valued not only for their clinical function but also for their educational and collaborative benefits. National survey data indicate that radiologists frequently appreciate exposure to clinical decision-making frameworks, feedback on imaging interpretation, and opportunities for learning and research collaboration.[1]

However, sustaining this educational value requires shared expectations regarding how discussions are conducted. Participants should be encouraged to frame contributions around the specific clinical question at hand, emphasizing information that directly informs diagnosis, staging, treatment selection, or follow-up planning. Academic or research focused discussion should be incorporated selectively and proportionately, ensuring it complements rather than displaces clinical decision making.

Establishing and reinforcing these norms promotes respectful, efficient dialogue and helps ensure that MDT rounds remain practical, inclusive, and focused on delivering timely, patient centered care.

Improve Technology and Infrastructure

Effective MDTMs are increasingly dependent on reliable, interoperable technology that supports efficient access to imaging and clinical information. This section outlines infrastructure and systems-level requirements needed to reduce duplication, improve image quality, and support seamless multidisciplinary review.

Integrate Imaging Systems

Recommendation 10: Improve integration between external imaging systems and local databases to streamline access to prior studies and clinical context. Ideally, equivalent functionality should be available for images/studies stored in external repositories.

Healthcare facilities must improve integration between imaging systems and clinical databases to enable streamlined access to studies. Provincial and regional PACS networks can provide secure, real-time access to imaging studies across all health authorities. This network should incorporate community imaging clinics through appropriate data sharing agreements and secure networking solutions, ensuring comprehensive access to all relevant imaging studies regardless of acquisition site.

Access to the provincial electronic health record should be available directly from interoperable PACS workstations, ensuring seamless integration and streamlined access to all relevant patient information during image interpretation and multidisciplinary case review. Implementation of robust image sharing networks between health authorities can facilitate timely specialist consultation and reduce unnecessary duplicate imaging.

Standardize Protocols

Recommendation 11: Develop and implement standardized imaging protocols across facilities to reduce the requirement for duplicate exams, diminish unnecessary radiation exposure, reduce administrative burden, and improve the quality of external cases.

Healthcare facilities should develop and implement standardized imaging protocols across sites to reduce duplicate examinations, minimize unnecessary radiation exposure, decrease administrative burden, and improve the quality of external cases. Protocol standardization should be governed by evidence-based guidelines and regular quality assurance reviews.

Artificial Intelligence (AI) tools can be strategically integrated into imaging workflows to improve standardization and enhance clinical efficiency. These tools should support image prioritization, automated measurements, protocol quality assurance, and critical finding detection. It is imperative that AI implementation occurs within established workflows and includes appropriate validation and governance frameworks.

Remuneration and Recognition

Despite the vital role radiologists play in MDTMs, their contributions are frequently under-recognized and inadequately compensated. This section emphasizes the need for remuneration and formal recognition models that reflect MDTM participation as essential clinical work.

Review Compensation Models

Recommendation 11: Advocate for appropriate compensation that reflects the time and expertise required for MDTM participation, including advocating for provincial fee codes.

Radiologists play a critical role in MDT rounds, yet current compensation structures rarely reflect the time, preparation, and expertise required for meaningful participation. More than 80% of radiologists report an increase in MDTM-related workload over time. Despite this rising demand, Notably, 93.8% of national survey respondents indicated that MDTM participation is not adequately compensated within their practice, and 92.2% reported insufficient compensation at the provincial level.1 In many jurisdictions, radiologists receive no compensation at all for MDTM work, and existing remuneration, when available, is highly variable, relying on fee codes (23.2%), practice plan funding (18.6%), or other undefined means.

MDTM participation requires substantial preparation that is not consistently recognized or compensated. The CAR recommends the development, refinement, and consistent implementation of provincial fee codes that accurately reflect the time, expertise, and clinical value contributed by radiologists during MDT rounds. Institutions should also be required to review and update internal practice plan structures to incorporate protected remuneration for MDTM preparation and participation. Aligning compensation with workload is necessary to sustain radiologist engagement, maintain high-quality imaging input, and uphold equitable, patient centered multidisciplinary care.

Acknowledge Contributions

Recommendation 13: Regularly recognize the contributions of radiologists in MDTMs to enhance job satisfaction and morale.

While compensation remains a critical issue, recognition also plays a significant role in radiologist engagement and job satisfaction. Survey results show that radiologists greatly value MDTM participation for its collaborative and educational benefits: 93.8% appreciate the interaction with clinical colleagues, 64.3% welcome feedback on cases, and an additional 64.3% note the value of research and academic opportunities.[1] Despite these positive motivators, the lack of formal recognition can erode morale, particularly in the context of increasing workload and insufficient compensation.

Institutions should therefore implement systematic approaches to acknowledging radiologists' contributions to MDT rounds. This could include annual recognition within departmental evaluations, highlighting MDTM work in performance reviews, incorporating MDTM leadership into academic promotion criteria, and officially recognizing the impact of radiology on patient centered decision making within hospital quality and safety frameworks. Demonstrating institutional appreciation for the expertise that radiologists bring to MDTMs helps reinforce the value of their contributions, fosters engagement, and supports the collaborative environment essential for effective multidisciplinary care.

Seek Feedback and Promote Continuous Improvement

Establishing operational standards is only effective if MDTM processes are regularly reviewed and refined. This section outlines mechanisms for auditing MDTM effectiveness and incorporating structured feedback to support continuous improvement over time.

Audit Effectiveness

Recommendation 14: Audit the effectiveness of MDTM working practices on a regular basis to identify areas for improvement.

Regular auditing of MDTM working practices is essential to ensure that rounds remain efficient, clinically focused, and aligned with institutional and provincial expectations for high quality patient care. Widespread issues, including inconsistent case preparation timelines, unclear clinical questions, variable adherence to submission deadlines, and insufficient compensation at hospitals across the country, signal systemic gaps that require structured monitoring to address effectively.

Institutions should implement routine audits of MDTM operations, including metrics capturing case volumes, timeliness of case submissions, adherence to cutoff policies, preparation time, meeting length relative to agenda, and the number of cases deferred due to meeting inefficiencies. Audits should also include an assessment of workflow burden on radiologists and other MDTM participants. These findings should be reviewed at regular intervals at the departmental or organizational level, with clear accountability mechanisms for flagging and addressing areas that are of repeat concern. Establishing structured audits will support continuous quality improvement and ensure MDT rounds function as effective, patient centered decision-making forums.

Establish Feedback Loops

Recommendation 15: Create mechanisms for radiologists to provide feedback on MDTM processes and suggest ongoing improvements, fostering a culture of continuous enhancement.

National survey findings demonstrate that radiologists are highly engaged in MDTM work and value the collaborative, educational, and clinical benefits of these meetings. Radiologists are therefore well positioned to identify inefficiencies, workflow barriers, and opportunities for improvement within MDTM processes.

Institutions should establish structured feedback mechanisms that enable radiologists to comment on meeting logistics, case flow, administrative support, technological barriers, and overall effectiveness. These mechanisms may include periodic surveys, structured post meeting evaluations, dedicated MDTM quality committees, or regular interdisciplinary review meetings.

Feedback should be systematically reviewed, with transparent reporting and clearly communicated action plans to close identified gaps. Embedding continuous feedback into MDTM governance supports accountability, reinforces multidisciplinary collaboration, and ensures that MDTM processes evolve responsibly and sustainably over time.

Conclusion

MDT rounds are an essential component of the healthcare journey for many patients, and radiologists often play a vital role in such meetings. By adopting these consensus-based standards, Canadian healthcare institutions can help to ensure that radiologists can continue to contribute meaningfully and equitably. These recommendations serve as a blueprint for delivering high-quality multidisciplinary care to patients with complex oncologic and medically high-risk conditions while balancing the increasing demands placed on radiologists within a sustainable and resilient healthcare system.

Methodology

To arrive at these recommendations, the Working Group assessed the data collected via the *CAR Survey of Patterns and Perspectives on Multidisciplinary Team Rounds in Canada*[1] and participated in a Delphi consensus process. The Delphi panel was composed of 9 radiologists from across Canada, representing different regions, practice environments, and areas of sub-specialization. The panel evaluated 15 core statements. Consensus was defined as ≥60% agreement threshold (rating of 4.0–5.0 on a 5-point scale). All 15 statements reached consensus in the initial round and were subsequently refined to incorporate qualitative feedback regarding urgent clinical exceptions and the prevention of administrative fatigue.

Acknowledgements

The CAR would like to thank the members who contributed their time, feedback, and experience during the development of this statement.

CAR MDT Working Group Members

Tanya Chawla (ON), Chair
Carolyn Flegg (SK)
Cameron Hague (BC)
Emil Lee (BC)
Elka Miller (ON)
Elsie Nguyen (ON)
Adnan Sheikh (BC)
David Volders (NS)
Kaitlin Zaki-Metias (MB)

References

1. Zaki-Metias K, Hurrell C, Miller E, Volders D, Chawla T. CAR Survey of Patterns and Perspectives on Multidisciplinary Team Rounds in Canada. *Can Assoc Radiol J*. Published online September 1, 2025: 08465371251365205. doi:10.1177/08465371251365205
2. Digby GC, Lam S, Tammemägi MC, et al. Recommendations to Improve Management of Incidental Pulmonary Nodules in Canada: Expert Panel Consensus. *Can Assoc Radiol J J Assoc Can Radiol*. Published online June 13, 2024:8465371241257910. doi:10.1177/08465371241257910
3. Gouliaev A, Berg J, Bibi R, et al. Multi-disciplinary team meetings for lung cancer in Norway and Denmark: results from national surveys and observations with MDT-MODe. *Acta Oncol Stockh Swed*. 2024;63:678-684. doi:10.2340/1651-226X.2024.40777
4. Lamb BW, Brown KF, Nagpal K, Vincent C, Green JSA, Sevdalis N. Quality of care management decisions by multidisciplinary cancer teams: a systematic review. *Ann Surg Oncol*. 2011;18(8):2116-2125. doi:10.1245/s10434-011-1675-6
5. Forrest LM, McMillan DC, McArdle CS, Dunlop DJ. An evaluation of the impact of a multidisciplinary team, in a single centre, on treatment and survival in patients with inoperable non-small-cell lung cancer. *Br J Cancer*. 2005;93(9):977-978. doi:10.1038/sj.bjc.6602825
6. Jiang W, Dou X, Zhang N, Yu J, Zhao L, Yue J. Multidisciplinary Team Meeting Significantly Enhances Disease-Free Survival in Stage II-III Rectal Cancer. *Clin Colorectal Cancer*. Published online December 28, 2024. doi:10.1016/j.clcc.2024.12.006
7. de Castro G, Souza FH, Lima J, Bernardi LP, Teixeira CHA, Prado GF. Does Multidisciplinary Team Management Improve Clinical Outcomes in NSCLC? A Systematic Review With Meta-Analysis. *JTO Clin Res Rep*. 2023;4(12):100580. doi:10.1016/j.jtocrr.2023.100580
8. Balasubramaniam R, Drinkwater K, Howlett DC. A national audit of radiology practice in cancer multidisciplinary team meetings. *Clin Radiol*. 2020;75(8):640.e17-640.e27. doi:10.1016/j.crad.2020.03.031
9. Balasubramaniam R, Subesinghe M, Smith JT. The proliferation of multidisciplinary team meetings (MDTMs): how can radiology departments continue to support them all? *Eur Radiol*. 2015;25(12): 3679-3684. doi:10.1007/s00330-015-3760-x
10. Elias Z, Tarique U, Veit-Haibach P, Kielar AZ. Standardizing Multidisciplinary Case Conferences and Improving Communication Between Referring Physicians and Radiologists: A Quality Improvement Initiative. *Can Assoc Radiol J.* Published online September 18, 2024:08465371241281055. doi:10.1177/08465371241281055