

Multidisciplinary Care

Team Dynamics, Decision Making, and Attitudes Toward Multidisciplinary Cancer Meetings: Health Professionals' Perspectives

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Abstract

Purpose: Multidisciplinary cancer care is a standard feature of high quality care. In many centers, the multidisciplinary meeting (MDM) is an integral component. A qualitative study was performed to explore health professionals' attitudes towards this model of care, the decision making processes, and dynamics among team members.

Methods: A series of focus groups was conducted with health professionals who attend MDMs at our institution. Focus groups followed a semistructured format with open-ended questions. A thematic analysis was performed.

Results: Four focus groups were held, attended by 23 participants including allied health professionals, specialist nurses, medical oncologists, and surgeons. All participants believed the primary objective of the MDM was to develop an individualized

treatment plan. Several other key themes emerged. The MDM provided opportunities to improve communication, efficiency, and education as well as enhance professional relationships. Medical information was prioritized ahead of psychosocial details, with allied health professionals describing difficulty contributing to MDM discussion. Patient attendance at MDMs was opposed by health professionals because of concerns about the patient's ability to cope with the information discussed and the effect their presence would have on the dynamics of the decision-making process.

Conclusion: Health professionals endorse MDMs as a useful tool in treating patients with cancer. Within this forum, both opportunities and constraints exist, with many benefits extending beyond the meeting itself into other clinical areas. Further study is warranted to establish an evidence base to ensure that both the possibilities and the limitations of this model of care are fully understood.

Introduction

As the complexity of treatment for cancer increases, so too has the need for co-ordination of care and sharing of knowledge between health professionals. Multidisciplinary cancer care has been shown to improve survival^{1,2} and adherence to evidence based-guidelines.³ It is now a standard feature of high-quality cancer care.⁴

In Australia, as in many other parts of the world, a central focus of multidisciplinary care is the multidisciplinary meeting (MDM), in which health professionals from medical and allied health disciplines review diagnostic imaging and pathology, jointly discuss a patient's case, and recommend a treatment plan. National guidelines suggest the treatment plan should include all therapeutic options discussed and, ultimately, a preferred treatment strategy. The plan is then discussed with the patient and modified according to individual preferences.⁵ This approach should result in evidence-based practice that is individualized for the particular patient. It also importantly incorporates shared decision making, which is preferred by patients and is a component of quality cancer care.^{4,6,7}

National practice guidelines for MDMs exist, predominantly based on expert recommendation.^{5,8} There are, however,

few empirical data in this area.⁹ We undertook an exploratory qualitative study of health professionals who attend MDMs to examine their views of MDMs, the decision making processes, and the dynamics within the meetings.

Methods

A series of focus groups was held with staff members who attend MDMs at St Vincent's Hospital (Melbourne, Australia). St Vincent's Hospital is a tertiary hospital and conducts regular MDMs for 11 different tumor streams. All health professionals who attend MDMs were eligible to participate and were invited via e-mail. Additional purposive sampling was undertaken to ensure all disciplines were represented. Radiation oncologists attend MDMs at the study institution but are located at a nearby hospital. They were unable to attend the focus groups. Focus groups were separated by clinical speciality in an attempt to maximize free exchange of ideas. Participation was voluntary. Written, informed consent was obtained, and the study was approved by the Human Research and Ethics Committee at St Vincent's Hospital.

Each focus group lasted approximately 1 hour and followed a semistructured format with a series of open-ended questions.

The questions were developed after review of the literature and supplemented with study-specific items of interest. The focus groups were voice recorded, transcribed, and analyzed thematically. Data analysis was performed independently by the three authors, and discrepancies were addressed through discussion and consensus.

Results

Fifty-seven health professionals were invited to participate in the study. Four focus groups were held engaging 23 participants, a level at which data saturation was reached. An interview was held for one participant who was unable to attend a focus group. The participants' demographic characteristics are summarized in Table 1.

The groups all believed the primary objective of MDMs was to provide a decision-making forum for clinicians to develop an individualized treatment plan. Within this forum, it is apparent that both opportunities and constraints exist. These identified opportunities were in large part, responsible for the overwhelming clinician support of this format.

Function of MDMs

Communication. Clinicians see their role as that of an advocate for patients discussed at MDMs. MDMs provide the opportunity for the health professional to be a spokesperson for the patient and encourage discussion that may not have taken place without this forum. This real-time treatment planning, cognizant of other expert opinion, was thought to encourage efficient and high-quality decisions. This is in contrast to the process that occurred before MDMs existed, in which a referral letter would be sent and the patient seen in an ambulatory clinic without direct face-to-face interaction between specialists.

"You're all in the same room together, looking at the same x-rays and discussing it . . . then you can come to a good conclusion rapidly." (Oncologist)

Deficiencies in communicating the treatment plan were described by many participants. The documentation ensuing from the MDMs often did not reflect the nuances of the issues discussed and sometimes did not reach the relevant health professionals in a timely manner.

"In some instances . . . there's been a lot of debate about whether they should have chemotherapy or radiotherapy . . . You don't get any of that in the summary . . . it just says 'to see medical oncologists.'" (Oncologist)

Efficiency. Health professionals found MDMs to be an effective tool in improving efficiency in the treatment pathway: minimizing patient travel by organizing investigations and outpatient visits in a time-effective way, coordinating hospital admissions, addressing the psychosocial needs of the patient early or arranging adjuvant treatment.

Education. Participants in all focus groups described the educational benefit of attending MDMs. Nurses and allied health professionals appreciated the opportunity to view pathology

Table 1. Demographic Characteristics of Participants in the Multidisciplinary Meetings

Characteristic	No.
Years worked in oncology	
Median	15
Range	2-34
Sex	
Male	8
Female	16
Profession	
Allied health	5
Medical oncologist	7
Specialist nurse	7
Surgeon	5

and radiology and achieved a greater understanding of medical care and the decision-making process.

"In terms of looking at the pathology and looking at slides and looking at how they make their decisions, I think it's a huge learning curve for us." (Speech pathologist)

Junior medical staff did not participate in the focus groups but were thought to benefit from witnessing the decision making of senior staff in devising a treatment plan. The meetings often prompted the formulation of professional development topics and also served as a forum to review the outcome of previous cases in which treatment decisions were difficult.

Enhanced professional relationships. Participants reported that MDMs have facilitated the incorporation of staff from traditionally diagnostic disciplines such as radiology and pathology into the treatment team, leading to closer working relationships. These closer relationships had a positive impact on other areas of clinical care outside the MDM.

"We're all ringing the pathologist all the time; there's a very interactive relationship because of the meeting." (Specialist nurse)

Decision-Making Process

Peer review. Clinicians value the MDM for the peer-review opportunity it provides. The MDM process was thought to provide a means of checks and balances and discourage inappropriate or unnecessary investigations from being conducted. Although clinicians felt the MDM provided some medico-legal protection, they still believed the treating doctor was ultimately responsible for the patient. No participants thought MDM participation exposed them to increased medico-legal risk.

"The clinician is still the responsible one but in some ways [we] go there more supported than we used to . . . almost [as if] the weight of the group takes a bit of responsibility off you." (Surgeon)

Presentation of information. In accordance with the MDM's primary function, priority was given to review of pathology, radiology, and the medical history during the meeting. Nursing and allied health personnel, in particular, commented that the

psychosocial concerns of patients were often neglected in favor of this medical information. Even within this medical discourse, oncologist's treatment recommendations were sometimes constrained by a surgical focus at the MDMs, with at times inadequate information on patient's comorbid conditions.

"It may be a fairly straightforward case . . . that we think we're going to give chemo to When we actually get to see the patient . . . they're . . . frailer . . . often that information isn't particularly well conveyed." (Oncologist)

Contribution to discussion. All focus groups acknowledged times when psycho-social information was crucial in the development of a treatment plan. Despite this, allied health professionals often felt inhibited when offering their contribution. Constraints appeared to be due lack of time and respect for their information. They described feeling as if they were interrupting the process between medical staff members and that their issues were often hurried along. Some MDMs were seen as intimidating and part of a "boys' club." Contributions were made easier when invited by another member of the MDM team.

Consent and Privacy

Health professionals believed patients should be informed of the MDM process, but no participant thought formal patient consent was required. MDMs were seen as representing a standard of care. Participants highlighted other meetings within the hospital system that discussed patient care in which patient consent was not obtained. Health professionals seemed aware of national guidelines recommending patient consent but largely saw them as bureaucratic edicts at odds with patient's wishes. MDMs were viewed as a confidential forum, and within this setting, participants did not have major concerns regarding patient privacy.

Patient Attendance at MDMS

Participants reported that patients felt reassured by their case being discussed at MDMs but unanimously opposed patient attendance at the meeting.

"I find my patients respond particularly well to me telling them I'll be discussing them at the MDM . . . they just want to feel they've had a panel of experts make that decision rather than just me." (Surgeon)

Health professionals described attendance at MDM by patients as being potentially terrorizing, overwhelming, and confrontational for the patient. There was also concern that the patient would not understand the MDM discussion and could not cope with hearing the expression of differing viewpoints. Patient attendance at MDM may, as a result, undermine trust within the doctor-patient relationship. Several participants noted, however, that the absence of patient input at the MDM meant that the treatment plan could not be viewed as complete until it was discussed with the patient and a final decision was made.

Health professionals were also concerned that patient attendance at MDMs would constrain the dynamics of the meeting.

The language used in the meetings to discuss treatment currently was at times fairly frank and blunt, with heated discussions on occasion. There was concern that the patients' presence might limit the expression of opposing opinions.

"It's a forum for the clinicians, to feel like they can put their views out there . . . trying to come to some sort of conclusion." (Social worker)

Discussion

Our research indicates that MDMs are endorsed by health professionals as a useful and time-efficient method of developing individualized treatment plans for patients with cancer. To our knowledge, this is the first study to explore health professionals' attitudes toward MDMs with respect to both the positive opportunities provided and the constraints imposed by this model of care.

Little research has been performed into the content and structure of MDMs. It is likely that this model has evolved over time to manage the workload and information requirements of each tumor stream at each individual institution. Similar to research by Lanceley et al,¹⁰ our qualitative study indicates that MDMs are primarily a medical meeting with a focus on pathology, radiology, and surgery, with limited contributions from nonmedical staff. Although Australian guidelines suggest psychosocial information be incorporated into all patient discussions,⁵ there are constraints, including concerns for patient privacy and a lack of time.

Our research suggests that the majority of allied health professionals felt distant from the MDM team and had difficulty incorporating their information and expertise into the medical model. Research into group decision making has shown that both contributions from members well known to the group and information known by several members are more likely to be considered when decisions are made.^{11,12} Consequently, allied health professionals are at a disadvantage at MDMs because they often possess unique information and are sometimes less well known to the group. Allied health professionals' contribution may be improved if strategies are developed to actively support and incorporate them into the MDM team and an acknowledgment is made of the valuable information they provide to the group.

Health professionals did not support patient attendance at MDMs. There were concerns about increased patient distress and the impact of their attendance on group decision making. There is substantial evidence showing that the majority of patients want to hear as much information about their cancer as possible.^{6,13} A pilot study of breast cancer patients attending MDMs showed no increase in anxiety. Although these patients perceived an improvement in information about their disease and its treatment, this was not substantiated in subsequent testing. Only half of clinicians surveyed were supportive of patient attendance.¹⁴ In light of the opposing views of clinicians and patients to patient attendance at MDMs, further inquiry is needed to explore its benefits and harms.

Consistent with the methodology of this exploratory study, these data may not be generalizable to a broader population.

However, our research shows areas of practice in which there is both significant concurrence and divergence from established MDM guidelines. This research is the first (to our knowledge) to detail the benefits of MDM that reach beyond the meeting itself, as well as the areas in need of improvement. Our research has highlighted future areas requiring investigation. Results of this study will inform the development of a questionnaire to be administered to a wider group of health professionals working in different hospital settings. This quantitative research will also include radiation oncologists and junior medical staff—groups not sampled in our study—from both tertiary and community hospitals and will determine the generalizability of the results in a broader group of health professionals. Little is known of patient's perceptions of multidisciplinary care. We are currently undertaking a qualitative study exploring patients' views on MDMs. It is only through the active engagement and incorporation of the views of all those involved in cancer care decisions that MDMs will function most effectively, and in a manner that health professionals support.

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Authors' Disclosures of Potential Conflicts of Interest

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