Multidisciplinary team meetings in palliative care: an ethnographic study

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ABSTRACT

Objectives Multidisciplinary team meetings are a regular feature in the provision of palliative care, involving a range of professionals. Yet, their purpose and best format are not necessarily well understood or documented. This article describes how hospital and community-based palliative care multidisciplinary team meetings operate to elucidate some of their main values and offer an opportunity to share examples of good practice.

Methods Ethnographic observations of over 70 multidisciplinary team meetings between May 2018 and January 2020 in hospital and community palliative care settings in intercity London. These observations were part of a larger study examining palliative care processes. Fieldnotes were thematically analysed.

Results This article analyses how the meetings operated in terms of their setup, participants and general order of business. Meetings provided a space where patients, families and professionals could be cared for through regular discussions of service provision.

Conclusions Meetings served a variety of functions. Alongside discussing the more technical, clinical and practical aspects that are formally recognised aspects of the meetings, an additional core value was enabling affectual aspects of dealing with people who are dying to be acknowledged and processed collectively. Insight into how the meetings are structured and operate offer input for future practice.

INTRODUCTION

Multidisciplinary team meetings (MDTMs) are a key component of palliative care practice in the UK. Yet, while MDTMs have been the gold standard in cancer care for over 30 years, there is a lack of existing literature internationally that describes the structure and function of palliative care MDTMs. MDTMs exist to ensure collaboration across professions.
and Tropical Medicine.

ethics committee at the London School of Hygiene

London Hospitals NHS Foundation Trust and the

Research and Development of University College

all relevant parties: HRA (IRAS project ID: 239197),

main, higher-

were shared during scheduled workshops in order

with the palliative care teams both on an ad hoc basis

against this background, we describe and analyse the

MDTMs of a hospital and a community-based pallia-

tive care team to provide insight into how the meetings

are structured and operate, to offer input for future

practice, and as the basis for future research into the

topic.

METHODS

Data were drawn from a larger ethnographic study

of palliative and end-of-life care in the UK. The

study focused on two affiliated multidisciplinary

palliative care teams in London, covering community

and hospital care. Data for this paper were collected

between May 2018 and January 2020 and comprise

observations of over 70 MDTMs. Observations were

primarily collected by AD, augmented by some made

by EB and SC, all of whom are anthropologists trained

in studying medical and health issues. Not being

healthcare workers or specialists in palliative care

ensured observations were made from an ‘outsider’s

perspective’, which provides a critical detachment to

the topic. Each meeting was observed in full, with

the presence of the researcher formally recorded and

made known to everyone attending. Field notes were

written both during and after each meeting in line with

the restrictions imposed by the HRA ethics approval.

All names, specific places and any identifying details of

individual staff members and patients were redacted.

Field notes were typed up, imported into NVivo V12

and analysed by the research team in two parallel oper-

ations. First, the pattern and format of each meeting

were identified and compared with each other in order
to generate a general summary of the structure of the

MDT meetings. And second, specific aspects of the

qualitative data were coded inductively and gradually

grouped in order to create higher level categories. These

preliminary topics and themes were then shared with

the palliative care teams both on an ad hoc basis and
during a number of scheduled workshops in order to

solicit feedback and help refine them. It is these main,

higher-level themes that are reported here.

Ethical approval for the study was obtained from

all relevant parties: HRA (IRAS project ID: 239197),

Research and Development of University College

London Hospitals NHS Foundation Trust and the

ethics committee at the London School of Hygiene

and Tropical Medicine.

Description of a typical meeting

At the time of the study, each team (community

and hospital) had approximately 20 staff; hospital

MDTMs were often complemented by people from

collaborating services (specifically chaplaincy, bereave-

ment services and/or pain team). The teams meet

independently on the same day and time each week,
on a day aligned with their joint teaching sessions.

Meeting spaces varied depending on the availability

of office space. At times, the rooms were too small for

the teams, especially if the projector was used for elec-

tronic note sharing and taking.

General format followed in both settings

MDTMs were usually attended by all healthcare staff

members, except the person covering triage and those

part-time staff who prioritised time to directly see

patients. The chair and note-taking functions rotated

to promote equality and skill development; one person

was charged with looking up any missing informa-
tion (such as date of referral, diagnosis) via a laptop.

In addition, they would confirm whether there was

any documentation of a patient’s wishes via an elec-
tronic system. Use of other computers and phones was

avoided to reduce distractions, although urgent calls

were always accepted.

The meetings were nominally scheduled to last

90 min. The format followed a standard structure;

introductions for any guests, brief discussion of

recent deaths across the part of London they covered

(allowing the bereavement officer to then leave),

more in-depth discussion of individual complex cases,

review of new referrals, an update on staff activities

day including joint visits and 1–1 meetings.

Discussion of complex cases was the core of

MDTMs. Colleagues were encouraged to nominate

cases prior to the meeting to facilitate record retrieval;

however, urgent cases were added during the meeting.

Each case presentation was led by one professional

(often the keyworker), who would narratively describe

the patient and their situation (known as the scenario),

with those also familiar with the case contributing

spontaneously. Discussion included overview of poten-
tial issues and areas staff felt required further support.

Attendees would ask questions and offer suggestions,

with the intention of reaching a consensus on next

steps—such as coordinating a joint visit between

different services. The amount of time complex case
discussions took varied; occasionally the teams used
discussion frameworks or timers to encourage concise
descriptions, particularly when there were many cases
to cover.

A summary of the case description and a list of action

points were formally recorded. The use of a number

of locally devised codes for record keeping—‘nature of

complexity’, ‘safeguarding or other risks’, ‘rapidly
changing condition’, ‘equipment’ and ‘social

support’—enabled more time for collective discussion

and reflection. In addition, Outcome Assessment and

Complexity Collaborative measures were agreed and

recorded to describe the stage of illness.9
Key observations
The physical environment affected how meetings unfolded; being cramped into a space and not able to see everyone hampered discussion. A sense of collegiality was established by informal introductions, humour at the start or end of the meeting and simple actions such as sharing fruit and biscuits. While not all case discussions were immediately relevant to all staff present, contributions from anyone were always valued. Different disciplinary perspectives helped question assumptions and provide complementary expertise. New members of the team rapidly learnt how to present, and relate to, complex cases by attending and participating in MDTMs.

While all team members saw MDTMs as a central part of their work, it tended to be framed as a management and administrative task rather than a direct form of patient care. At times, staff expressed concerns that attending meetings reduced time available for interacting with patients and their families, an aspect of their work that they highly valued and was often pressurised due to workload volumes. But in addition to supporting clinical and practical concerns, such as treatment decisions, agreeing joint-visits or tracking patients as they moved between acute and community settings, we observed that MDTMs served several other functions. Staff were able to express their own emotional response to cases that were often complicated and frustrating to deal with. Although these affectual dimensions could not always be resolved, sharing them with the team shifted responsibility and burden from individual professionals to being acknowledged and taken on by the team. Our findings indicate that there can be a difference between what staff perceive the use of meeting to be, which may be more administrative, and the value of the meetings when considering how they influence patient care, staff well-being and collaborative working.

Standardised codes and team discussions established a shared understanding of what a complex case was. Often this related to instances when it is not clear what should happen next or who should take the lead for subsequent actions. Even when no new clinical decision arose, the opportunity to explore different possible ways to proceed had real value, cultivating individual and collective capacity to respond. Since many complex cases were discussed repeatedly at various MDTMs, a longitudinal perspective emerged that helped inform suggestions for how to proceed.

Discussion
Research into MDTMs, and our own observations, indicates that they have several implicit and explicit functions. They are beneficial for teamwork and patient care; they provide attendees with the opportunity to gain awareness and appreciation of views central to different professions. Professionals find them useful, providing a comprehensive approach to care viewed as integral to palliative care, even though there is complexity in the communication during meeting and meetings can be time-consuming.

Although the effectiveness of MDTMs is regularly considered, rather than solely being opportunities to plan or make decisions about patient care, MDTMs provide support for individual professionals and are highly valuable for the solidarity and continuity of the team itself. While discussion of difficult cases is not intended to have therapeutic value for staff (they have other support systems for this), it nevertheless often helps individuals feel supported, release emotional burden and shift a case from being experienced as a personal burden to one the whole team takes responsibility for. Additionally, the regularity of meetings allows for the sharing and accumulation of expertise among members as well as informal training for rotating and new staff.

The MDTMs we observed differ from other MDTMs, such as those that follow cancer peer-review criteria to discuss all new referrals or other integrated community palliative care teams that are linked with hospices. Through the Forms of Care project, senior team members reflected on these elements, suggesting further work may be needed in terms of setting ground rules and articulating the major values of meetings.

There are several recommendations from our observations:

The space where a meeting is held often matters more than may be realised; this was noticed by the teams especially after doing online meetings (after data collection finished). Not only can it impact contributions and collegiality but also can impact the value accorded to the meetings.

An agreed format and prescribed timings help convey expectations while also ensuring that the meeting does not overrun; however, some flexibility is essential in order to respond to specific issues and concerns that can be raised during the course of discussion.

Documenting action plans during the meeting, rather than after, improves record keeping and ensures that staff are clear about what has been decided. Varying who fills in the documentation can share workload and build confidence with using clinical and/or administrative codes.

Ongoing discussion about the format, outcome and experience of meetings can help align meeting activities with team objectives and strengthen interprofessional relationships.

The total value of MDTMs can only be appreciated by recognising the wide range of additional aspects, beyond merely the clinical and social support decisions that are officially recorded.

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Contributors All of the authors meet the criteria set out by the International Committee of Medical Journal Editors
Short report

Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals.

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