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Multidisciplinary team meetings: dynamic routines that (re)make palliative care

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ABSTRACT

Multidisciplinary team meetings are part of the everyday working life of palliative care staff. Based on ethnographic material from community and hospital palliative care teams in England, this article examines these meetings as dynamic routines. Although intended to have a prescribed format to review deaths and collect standardised information to monitor service performance, in practice, the content and conduct of the meetings were fluid, reflecting how this structure did not always match the concerns held by the team. The meetings provided a means for the team to collectively enact and weigh up different values through distributing the care and responsibility for individual patients across the team; jointly 'feeling their way' to determine what care should be offered and in what form; and by caring for their own professional wellbeing in the context of metric-driven healthcare. We observed how staff experienced tensions in 'documenting care' because of a concern that this misrepresented what they felt were core aspects of their role. Whilst team meetings may be considered a formal, routine part of teamwork and care, we interpret them as a dynamic social practice during which palliative care teams continually question 'what really matters' and (re)make what palliative care practice should entail.

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Introduction

Meetings are a fundamental part of institutional life across many sectors of industrial societies. In the United Kingdom (UK), the increasing importance of conducting clinical audits during the 1980s promoted regular specialist team meetings designed to provide ongoing training and case review. These evolved into routine multidisciplinary team (MDT) meetings (sometimes abbreviated as MDM or MDTM), which have been a 'gold standard' in UK cancer care since the 1990s (Warner et al., 2021) and have since been globally adopted across many fields of medicine (Hoinville et al., 2019). Research

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on healthcare has frequently argued that teamwork is fundamental to the successful delivery of patient care (Baker et al., 2006; Klarare et al., 2020) and perceived by staff as vital for avoiding burnout (Parola et al., 2018).

Drawing on this trend, a multidisciplinary team approach is a common part of specialist palliative care internationally (Fernando & Hughes, 2019). Within England, commissioning guidance expects palliative care services to have operational policies for multidisciplinary working, including regular MDT meetings to collaboratively review patient cases and develop best practice (NHS England, 2016). Disciplinarity diversity in palliative care teams is represented both in role and background; teams consist of consultants, junior doctors, nurses, occupational therapists, physiotherapists, social workers, and spiritual carers, although their precise composition is contingent on funding and setting (Firth et al., 2019). These MDT meetings are perceived to be a cornerstone of how to practice palliative care, both within the speciality and in order to support other medical specialist meetings, such as oncology (Firth et al., 2019; Kaasa et al., 2018). As such, MDT meetings are a 'routine' practice (Feldman et al., 2016) that involves regular enactment, collaboration, and communication.

Much of the existing literature on teamwork and interprofessional collaboration involving palliative care is interview or focus group based (e.g. Bennardi et al., 2022; Borgstrom et al., 2024; Klarare et al., 2013), or if ethnographic, focused on particular patient-populations (Carter et al., 2023) or forms of symptom management (Arber, 2007). Where research exists on MDTs meetings specifically, it tends to focus on cancer care (Kruis et al., 2016). It is notable, therefore, that whilst attending and participating in MDT meetings are central to the work palliative care professionals engage in, there is a surprising lack of literature examining their structure and function (Borgstrom et al., 2021; Furman et al., 2018). This article consequently focuses on these meetings in order to understand their role in care provision. We do so by theorising them as dynamic routines, a term that allows us to demonstrate the team's ability to 'feel its way' through complex cases, establishing shared ways of working and responsibilities between team members, and deal with the tensions that accompany the use of metrics in practice.

Methods

The material in this article was drawn from a larger ethnographic study of palliative and end-of-life care in the UK, which focused on the concept of non-intervention as a form of care. For this study, practices were understood as epistemologically situated. All three authors are experienced ethnographers with training in anthropology and/or sociology but have no clinical or social work background. Each author has varying research expertise in palliative and end-of-life care and experience of fieldwork in the NHS. We have published elsewhere about the wider methodology of the study, including the paradox of trying to study interventions that were not undertaken or resisted, and the techniques we have used to do so, of which attending MDTs was one point of data collection (Borgstrom et al., 2020). In addition to the MDT meetings, AD shadowed staff in their daily work practices, interviewed 39 staff, and held repeat interviews with three patients and one relative. Data were managed within NVivo 12. Select anonymised interview data from the study are available in the UK Data Service repository (Cohn et al., 2021). For

the purposes of this article, we have mainly drawn on the material from meetings and interviews with staff.

The study worked with two (of over a dozen) multidisciplinary palliative care and end-of-life care teams in inner-city London; one providing care at the community level, another in a large hospital. Both offer multidisciplinary assessment, care for patients and family members, as well as staff support and education. Although operationalised as two distinct teams, individual staff members occasionally transition between the settings as do some of their patients. Close collaboration with the teams for this study facilitated an approach that enabled them to reflect on their practice rather than offer critique or judge from an external vantage point. Ethical approval was obtained from all relevant parties: Health Research Authority (HRA) [IRAS project ID: 239197], Research and Development of University College London Hospitals NHS Foundation Trust, and the HRA's Confidentiality Advisory Group, because we would be present at meetings about patients without their direct consent. All names in the article are pseudonyms.

Data collection occurred between May 2018 and January 2020. The research team (consisting of all three authors) observed over 70 MDT meetings, with AD attending most of these. Ongoing process consent from staff was used for observing meetings. Initially, the meetings of these two teams took place on different days and we could attend both meetings. After six months of fieldwork, the MDT of the community team was rescheduled to follow weekly teaching sessions, mirroring the model adopted by the hospital team. While this streamlined the team members' calendars, it meant that, as researchers, we had to alternate weekly attendance between the two settings.

Field notes were written up during and after each meeting. Focus was not on the details of individual patients, but how cases, decisions, and care practices were discussed and negotiated. When more than one researcher attended a meeting, we compared and combined notes to facilitate collaborative analysis. To minimise the collection of personally identifiable data, the meetings were not audio-recorded.

Engaging with palliative care MDTs and NHS-based fieldwork for the first time via this study, AD was able to initially approach fieldwork with a descriptive aim, which enabled analysis to build on documented patterns in the data. The research team regularly reviewed fieldnotes to identify common topics and areas of interest, using memoing, letter writing to each other, and frequent team discussions to inform further data collection. Through this iterative process, we identified elements of the data that intrigued us, seemed to present a deviant case, or exemplified existing theoretical views about biomedicine, care, and/or interprofessional working. Throughout the study, we shared our interpretations with clinical collaborators to explore resonance, followed up specific angles in interviews, and preliminary analysis was shared with palliative care staff through Collaboratory workshops. Feedback from a session on 'communication' in June 2019 refined our focus on MDT meetings as a focal point to understand how the teams functioned and the kinds of care they provide beyond the patient bedside.

Drawing on practice theory approaches and the concept of routine dynamics (Feldman et al., 2016; Nicolini, 2013), which align with the study's epistemological and ethnographic approach (Borgstrom et al., 2020), EB then reanalysed the data on meetings, including our memos, letters and feedback from our collaborators. MDT meetings were identified as a routine – 'recognizable, repetitive patterns of interdependent action carried out by multiple actors' (Feldman et al., 2016, p. 505) – but also dynamic over time,

meaning they were similar but never the same. This analytical perspective acknowledges that action is situated, actors are knowledgeable and reflective (and actants can include ideas, objects, models, and non-human elements), and that stability is an accomplishment (Feldman et al., 2016). Through this approach, the theoretical concepts of relationality and multiplicity are useful for thinking through the actual and potential connections between actions that are part of routines. Like studies on ‘mundane practices’ and ‘everyday participation’, the focus is on ‘how practices are produced through collective endeavour’ rather than by individuals and their choices or interpretations (Ebrey, 2016).

Because previous organisational research has been critiqued for not describing how routine things like meetings actually take place (Okhuysen & Bechky, 2009), the first part of our findings below provides an overview of the meetings and why certain elements occurred the way they did. We then draw on Nicolini’s suggestion to ‘zoom in’ and ‘zoom out’ in order to present meetings as an accomplishment, and to highlight the ‘trails of connections between practices and their products’, understanding how it ‘reproduce[s] existing social arrangements or generate tensions’ (Nicolini, 2013, p. 218 and p. 230). In doing this, we turn our attention to two sets of activities – complex case discussions and the use of metrics and forms. These examples demonstrate how what is done in the MDT meetings is constituted of and constitutes a wider set of actions – like ‘bedside patient care’ – and actants (patients, other clinical teams, hospital managers) that are understood to be part of what it means ‘to do palliative care’. The interweaving of first-hand description and analytical observations reflects our commitment to the ethnographic approach of the overall study.

Results

Overview of MDT meetings: dynamic routines of weekly meetings

Palliative care team meetings happened every week and were typically referred to as ‘the MDT’. The stated purpose of these meetings was to share information and to enable different disciplinary perspectives to provide expertise. The number of attendees varied weekly, depending on shifts, annual leave and if student nurses were visiting; the expectation was that all health care staff except the person covering ‘triage’ (referrals or queries coming into the team) and part-time staff who spent their limited time directly with patients, would attend. Hospital-based meetings were usually held in a room partitioned from an otherwise open-plan shared office space; community team meetings were in a meeting room or sometimes an empty patient room in the rehabilitation ward. In both sites, everyone would sit around a large table: the space was generally too small to accommodate everyone easily, especially after the introduction of the use of a projector to share the electronic patient files, so people formed a second row of seating as best they could.

There were only two specific roles adopted – Chair and Note-taker. These were rotated to avoid instilling a sense of hierarchy and, according to one of the team leads, to facilitate staff skill development. Although such efforts were made to ensure meetings felt inclusive, the more senior clinicians and those staff with greater experience tended to lead the discussions (and often found a seat around the table), with some other attendees saying very little. Some nurses described how they felt the ‘need to perform’ and that if the consultant was not present ‘there was no sense in [having a] meeting’ and their time could be

'better used at the patient's bedside'. So, whilst the clinical leads were committed to the idea all team members could contribute, individuals had differing perspectives and levels of engagement.

As people drifted in before a meeting formally began, they engaged in small talk, gossip, and shared any snacks someone brought in (an unofficially rotated responsibility, including treats from recent holidays or to mark personal celebrations). Attendance was noted: if somebody came late, the attendance list got immediately pushed in their direction. The meetings were always scheduled to last 90 minutes, and given the pressures on staff time, the team tried to ensure meetings did not overrun. Every meeting followed a standard general structure, although as we describe, there was flexibility in how things unfolded.

After a round of introductions for anyone new attending, the Chair would formally introduce the first agenda item – listing patient deaths over the last week. As the names were read out, different team members would chip in with any details they had about the individual circumstances, while others who may have had recent dealings with the patient were able to acknowledge the news, and perhaps remark that the person had been expected to die soon or sometimes expressing surprise if the death had not been anticipated. Ostensibly, team leads claimed that the purpose of this part of the meeting was simply to notify everyone about who has died and no longer is under their care, as well as collect any missing pieces of information needed for the records (where they died, if they had preferred to die at home, etc.). But it also served another purpose: the reading out of names not only presented those who had recently died as a *group* of patients, but this in turn underscored a sense of the collective across the palliative care team. So, even if only one or two individual staff had had direct dealings with patients mentioned, by listening to the list, everyone present effectively was acknowledging the efforts that had been invested in and that, as a group, they remained committed to a common goal. This outcome was so valued by the team that they sometimes found additional occasions to list those patients who had died in their care and reflect on the work they did as a team.

The remainder of the meeting tended to focus on the care of some of the new referrals, patients deemed to be 'complex cases', a brief update on the specific activities of staff and organising any joint visits or 1–1 meetings that needed to be arranged. However, the order of these elements was flexible, depending on who was present during the meeting and the number of cases to be discussed. Each of these elements had its own set of documentation: used to prompt questions for discussion and recording of information and decisions. At one stage there was an attempt to streamline the meetings because patient numbers had risen so much that there was concern not all the important cases would be discussed. Interestingly, the curtailed format did not last during the study because staff, declared in the meetings and our study workshops, found it too rigid and documentation-driven; after time, the more typical combination of formal business and team chat resumed.

Discussing 'Complex' patient cases: beyond the clinical

Talking about individual patients was the main feature of every MDT meeting in terms of the amount of time devoted to it. Weekly, the team collectively saw more patients than could be discussed in any meeting. But of these, some cases were presented as especially

complex and so were prioritised for discussion. Staff were encouraged to nominate complex cases beforehand, enabling records to be retrieved in advance; however, they sometimes might just add a name to the list during the meeting. Checks were made to see if there were any records on the local area's digital system (called Co-ordinate My Care), which might contain details about any advance care plans, preferred place of death, or the patients' religious or spiritual beliefs. During our study, we observed how criteria for what constituted 'complex' (or complex enough) shifted depending on the pressures the teams were facing. Sometimes, this was down to the sheer number of patients being cared for, with higher patient numbers requiring selection based on explicit clinical predicaments, such as a high pain score, or treatment uncertainties. But at other times, the nomination of patients was for less explicit reasons, with the nature of complexity only becoming apparent as discussion unfolded. Discussions tended to start with one person first outlining the clinical details, then the wider circumstances including mental health and social aspects, and finally clarifying why the case might be seen as complex. Others would then ask questions and provide suggestions, with the aim of reaching a consensus on what next steps should be taken or, indeed, whether the best thing was simply to wait and see how things developed. All the while, someone would be taking notes. Sometimes, the account might not initially be recognised by others, but as the discussion continued, they might realise that they, too, had had some dealings with the patient. A great deal of care was taken to present these cases. As demonstrated in their accounts, staff were committed to providing as rounded a picture as possible, mentioning acquaintances who were part of a patient's network, what relationships they had, how they may have come across during a recent visit, whether they seemed aware or wanted to know more about their health status, and so on. Staff might mention the patient's living conditions or what profession they had. And they might also try to convey the patient's emotional state and that of those around them, as well as sometimes how the case made them feel as well. Frequently things centred on the difficulty of balancing competing requirements – ranging from the effects and interactions of medication to the practicalities of the patient being able to stay living in their home.

By sharing these accounts, the emerging descriptions become part of the narrative construction of the cases, whilst simultaneously opening them up for joint exploration and interpretation. Although individual staff may well do their best not to hold inconsistent opinions and base their decisions on current clinical evidence and previous experience, the diversity of staff at the meetings encouraged contradictory positions to be valued and explored. Indeed, the very impetus that comes from turn-taking encouraged others to suggest alternative or contrary views for the group to think about – or as one staff member put it, to 'feel their way through'.

Many complex cases were repeatedly discussed at different MDT meetings as the patient's situation evolved. This provided a crucial longitudinal perspective that shaped discussion and decisions going forward. Importantly, such cases also demonstrated that an intrinsic aspect of the complexity the staff were trying to get to grips with rarely led to a singular solution or intervention that could be enacted. Ongoing discussions enabled the team to hold space for recognising that the process of dying was inevitably unpredictable, unstable, and uncontrollable, and as such, that deciding the best form of care needed to be an ongoing response to this complexity.

To illustrate this, we provide the example of Meiyong. Miriam, a palliative care doctor, had been looking after Meiyong for over a month before the case was presented to the hospital MDT for the first time. Meiyong had come over from China to the UK on a tourist visa with metastatic cancer and a prognosis of only months to live. She had been given emergency treatment at the hospital but was not eligible for any chemotherapy or ongoing treatment because of her visa status. Nevertheless, the oncologists enlisted the palliative care team for symptom management and ‘psychosocial’ support. Miriam described Meiyong as being very distressed, noting that the oncology team had done everything possible that they could. Miriam reckoned that the patient probably had ‘a small window to be well enough to fly home’, and that the team needed to take into account that she had ‘no friends here, no family here, and she’s not eligible for any treatment here’.

Whilst the MDT agreed it would make sense for Meiyong to fly back to China, Meiyong did not want to return and was not assessed as being ‘medically fit’ for discharge because she had no UK accommodation arranged. As time passed, the general hospital staff increasingly struggled with what they felt was her erratic behaviour on the ward. So, Miriam brought the case back to an MDT meeting. She told her colleagues that a senior ward nurse doubted the patient would ever go back to China, and that she was likely to be ‘on the ward forever, until she dies’. So, Meiyong remained under the team’s care, even though they were far from confident this really was the best option. Like many other complex cases, Meiyong’s situation did not have a straightforward solution; it was nominated as a complex case precisely because there were different competing values that potentially clashed. In such instances, the function of the MDT is not to arrive at a definitive decision but instead allow staff to present accounts of patients that are inherently demanding and unclear. In doing so, everyone sitting around the table acknowledges the uncertainty, which may well mean that for the time being at least, things should be allowed to remain unresolved.

Such discussions provide a vital opportunity for individual staff to share their frustrations and dilemmas, and so shift these from being experienced as a personal burden to ones the team as a whole acknowledges and takes responsibility for. Recognising this as something they were doing, the teams joked that cases could be nominated as complex to ‘maintain the sanity of the key worker’ or check if they might have ‘over-stepped’ things. Whilst not an official function of the MDT meeting, and although there were 1–1 supervision meetings for such purposes, everyone agreed that the constant work pressures motivated them to ‘share the burden’ and, at least temporarily, to alleviate personal anxiety. The accumulation of detailed information enabled staff not only to relate to the individual patient, but also connect with each other in the room. This process was, therefore, not only an opportunity for staff to share apparently ad hoc pieces of knowledge alongside the more standard clinical information documented, but also establish a shared narrative that brought together diverse sources of information and insight. Appreciating this range of information was important to the team; in project workshops they noted that they felt it reflected their person-centred holistic approach to care. Overall, presenting cases as complex, and inviting input from everyone at the meeting, enabled the team to *distribute* care. By this, we not only mean that the team come to share the demands and difficulties of individual patients as they hear and discuss specific cases, but also that the very idea that palliative care is something that

the team does as a collective, rather than a set of tasks done separately over the course of the week, and includes care of the team.

Data and forms: the use of, and tensions with, metrics and documentation

At several points during MDT meetings, specific metrics were collated or discussed, usually facilitated through various types of documentation. Sometimes this appeared so mundane that it was not questioned by anyone, as with the ‘roll call’ of recently deceased patients described earlier. At other times, issues of quantification were explicitly debated, especially when it raised questions about how to ensure the wide-ranging value of the palliative care team could be made more visible. One of the team members remarked that perhaps all the forms and documents, which were the primary means for work to be quantified, were just an attempt ‘to bring order to what is a fundamentally a messy part of life: death and dying’.

As the team talked through patient cases, discussions were often guided by the formal documentation that the note-taker had to fill out. Going over each data section not only allowed for the ‘headline information’ to be rapidly shared amongst the whole team but provided a structure to collate the various items of information. Contributions would follow on from each other as staff recalled the various interactions they had. In some meetings, the note-takers would remark how many empty boxes there were in the CMC digital record, especially for advance care plans and any known religious beliefs a patient may hold. Whilst in other clinical contexts missing information might be seen as a problem that requires action or that might even be reprimanded, everyone in the palliative care team was all too aware how difficult it was to obtain much of this kind of information, especially because they were committed to the idea that the patient should lead conversations as much as possible. In addition, because these ‘tick box’ systems were felt to not capture the full range of what they provided or what was most valued by patients, such checks frequently prompted staff to reflect on their work, and what they as a team felt were the most important aspects of their service. Leaving the boxes empty effectively allowed for a space for them to resist quantifying their work and invited them to reflect on their goals as a palliative care team.

The collection of such data prompted discussions about the growing role of key performance indicators (KPIs), and predictions about what formal measures their local NHS employer might introduce. This was particularly the case for data about the preferred place of death (and if this preference was achieved when reviewing who had died), which has become a common metric in end-of-life care. Much has been written about the problematics of ‘preferred place of death’ as an outcome measure, and the team were well versed in such arguments. However, the lead consultant stressed in an MDT meeting that rather than try and reject it outright, the team needed to think strategically about what gets recorded, and how it might be (mis)interpreted. For example, a patient who had died in hospital may have a record that stated ‘hospital death – preferred place of death not met’, but this might not capture the fact their preferences may well have changed as their condition deteriorated, and that the records simply had not been updated. His suggestion, therefore, was not to spend energy resisting these ‘crude measures’, but instead find ways to make sure they better captured the intricate and multifaceted work the team did.

One strategy to address this was to continuously log work, using the MDT meetings to articulate precisely what had been done. Ironically, however, the team devised yet another form to record all the various steps and plans that were being thought through, such as needing to speak to the patient or waiting on a test result. But what was distinct about the team's own system was that it also captured instances when no action was decided on. Whilst not fully compatible with quick audits and KPI measurements, writing everything down was a strategy to ensure their work would not be reduced to a handful of measures. Instead, they sought to render visible the multidisciplinary and multi-layered nature of their work. This was not adopted without question, however, as it raised concerns shared both inside and outside of the MDT meetings about what really was the 'best use' of their time. Some staff argued that this initiative was more about 'proving' the care they provided rather than 'improving' it. Others accepted that it was increasingly necessary to document activities, but felt the records should be rationalised and focus just on identifying patterns and issues that required change. During our study, the teams tinkered with how to best use documentation to support their own discussions, rather than see them as requirements imposed upon them by others in the health service.

The debates about what things to formally record, and the advantages and disadvantages of simple metrics, point to a tension that the palliative care teams were never able to resolve; that the drive to be more efficient and focused was often at odds with their commitment to care for their patients holistically by taking everything into account, and recognising that the apparently small details of an individual case often mattered. The team's debates about how and to what record revealed differing perspectives on how documentation and measurement can be part of, or counter to, care or care improvement. In this way, we contend that documentation and measurement cannot be deemed as inherently good or bad, facilitative or disruptive, but rather integral to shaping team interpretations of what they do.

Discussion

As others have noted, regular meetings in healthcare settings often have multiple purposes, of which clinical decision-making is only one aspect (Paulsson, 2022). By their very nature, multidisciplinary team discussions facilitate information exchange, strengthen the continuity of care, encourage interprofessional working, provide a forum for education and learning, improve well-being and work satisfaction for individual team members, and be a site for research (Taylor & Ramirez, 2009; Wallace, 2017). Adopting this broader approach aligns with what has been shown more generally about work meetings; that often their official purpose belies many other, more tacit, functions. In parallel with any management claim that they are an 'instrument for getting things done with maximum efficiency' (Strathern, 2017), meetings importantly provide an opportunity for people to come together and take collaborative action, creating 'specific and productive arenas in which realities [social worlds contained in and animated through the meeting] are dramatically negotiated' (Brown et al., 2017, p. 10). From an anthropological and sociological point of view, meetings are never merely secondary to the 'real work' done outside of them, but rather are social practices in their own right that forge a shared understanding of what work needs to be done, what things are important, as well as what is not acknowledged or talked about.

In this article, we have approached MDT meetings as a particular type of social practice; a work routine that nevertheless remains dynamic. The meetings are routine in that they occur regularly, with multiple actors deploying ‘repetitive patterns of interdependent action’. But an intrinsic quality of them is that they remain dynamic and always have the potential to ‘change from one performance to the next’ (Feldman et al., 2016, p. 505). Our study illustrates how this describes not only the main features of the MDT meetings we observed, such as listing patients who have recently died and discussions of complex cases, but also all the smaller, interpersonal moments that may appear inconsequential. Routine dynamics emerge both through their own enactment and in relation to the other practices (Feldman and Orlikowski 2011), creating what Rentland and Rueter call an ‘effortful and emergent accomplishment’ (1994). The content of each meeting is never fully prescribed because indeterminacy always arises from encouraging interaction between those who are there. So not only are variations to be expected, but there will always be a steady flow of new things being added and other things being dropped.

It is worth also pointing out that maintaining the commitment to have weekly meetings is not a straightforward matter; there is increasing concern about the resource costs of committing so many staff in a room together, as well as questioning whether they really do lead to greater clinical efficacy (Pillay et al., 2016; Taylor et al., 2010). At a time when the UK’s healthcare system is increasingly under pressure (Picker & Raleigh, 2018), activities that do not have a definitive, instrumental purpose are often felt to be ‘under persistent attack’ (Okhuysen & Bechky, 2009). The effect of these external critiques was reflected in some responses we observed, including an attempt to apply more rigid criteria to what cases should be discussed, and reflecting on what information should be formally documented (see also Moser, 2010 for discussions of proving care). Although these did not lead to permanent changes, they served to catalyse a shared conviction about what the real value of the MDT meeting should be: namely, spending time collectively to understand and work through particular aspects of ‘doing palliative care’ rather than simply increasing the number of clinical decisions being made. The teams’ ability to focus on sharing stories and encourage discussion is interpreted as an example of how they attended to the integrating conditions of the routine, rather than focus on the mechanisms for coordination for such meetings, which would have looked like consistently insisting on a rigid selection process for complex cases. Their approach to prioritise integrating conditions rather than mechanisms for coordination aligns with their philosophy of seeking to provide holistic care that is adaptive to the person/patient they are caring for.

Previous research on teamwork in palliative care indicates that communication, including meetings, is part of what enables teams to ‘feel like a team’ and develop collaboration (Klarare et al., 2013). We found that this process arose from a subtle combination of formally required procedures and processes, combined with more informal elements that served to consolidate the multidisciplinary team and allow them to share some of the stresses and personal challenges that were an intrinsic part of the job. In fact, these more informal aspects were clearly valued and protected by everyone, although they were never presented as a main, core function. Sharing this insight with some of the clinicians confirmed the importance of combining these elements, even though much is not formally recognised beyond the teams.

Theorising the MDT meetings as dynamic routines, provides an analysis that captures how teams respond to such outside pressures yet also maintain a sense of stability and cohesiveness. Firstly, the meetings enabled the teams to hold space for ambiguity about what to do and *not* to do (elsewhere, we have demonstrated this is a core quality of palliative work – see Cohn et al., 2023, 2024), allowing care to be emergent quality of a specific situation rather than a pre-determined protocol. This is especially pertinent when opening up discussion to cover non-clinical as well as clinical challenges that come with dealing with dying patients and their relatives (Dewhurst et al., 2024). Secondly, sharing knowledge and responsibility enabled the team to shift patient care from being linked to one ‘key worker’ to a concern distributed across the team. This resonates with research in other aspects of healthcare, that describes how meetings serve to reassign accountability, facilitate team building and creating a collective identity, and enable knowledge sharing (see also Devitt et al., 2010 for cancer care). Lastly, the meetings enabled staff to care for themselves and each other, by providing a bounded and safe space for emotions, frustrations and uncertainties to be expressed without judgement. Our account makes clear that these kinds of ‘peripheral practices’ are nevertheless core to ensuring the ongoing provision of palliative care for patients as well as adequate ‘care for the carer’ (Popa et al., 2024), and therefore are far from being unimportant.

Concerns about how best to make all the subtle and apparently insignificant features of care work, that cannot be captured by audits or rigid metrics, more visible is not exclusive to palliative care. Toffoli et al. (2011) note in their ethnographic study of nurses in Australian hospitals that even though performance measures were meant to make all nursing activities more visible, they cannot fully capture all that the nurses did, instead having the effect of further commodifying care work. Bolstering this argument, Hoeyer and Bødker (2020) note that healthcare systems are ‘saturated by processes of datafication’, which risks eroding care and disempowering staff. They claim that whilst there is nothing inherently wrong with documenting the achievement of goals, it becomes problematic when tasks are assumed to be simply technical issues. In addition, the resulting data can be used to hold individuals, teams and entire organisations accountable. Our research adds to this by illustrating how a focus on data and documentation can be troubling if such measures are assumed to be linked unambiguously with clinical quality surveillance, as they neither reflect the range of care provided nor address the complexity that professionals and patients face. Our observations of the team discussions around what to document and count also link to wider sociological questions about what counts as quantitation, who governs it, and ‘how social, technical, and political factors interact to make stable numbers’ (Berman & Hirschman, 2018, p. 258). Our research demonstrates how palliative care teams can be agentic in shaping the measurements that, in turn, may shape how the service is evaluated by others, to calibrate these in ways that reflect how the team understands care.

Overall, we have highlighted how, whilst MDT meetings may be considered a formal, routine part of teamwork and care, our ethnographic observations reveal them as a dynamic social practice during which palliative care teams continually question ‘what really matters’ and (re)make what palliative care practice should entail. The meetings allow for a broader, heterogenous consensus about what constitutes relevant information, and establish ways to connect non-clinical and emotional dimensions to the clinical and technical details (see Dew, 2016 for MDT meetings in general). This is particularly

important in the context of end-of-life care, where patients often experience a range of things that are beyond the clinical expertise of one specialism (McNamara & Rosenwax, 2007). These dimensions, and the strategies teams adopt to acknowledge and manage complexity, are often not recorded in the official data records and notes, yet constitute central activities during the meetings, and crucial aspects of the care that is provided. We observed this both in the discussions around ‘complex cases’ as well as data and documentation. Appreciating MDT meetings as dynamic routines provides an understanding of the ‘accomplishment’ of palliative care in a context where deliberations about how best to care for patients and ‘measuring outcomes’ are increasingly felt to be oppositional.

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