

Facilitators and Barriers to Teamworking and Patient Centeredness in Multidisciplinary Cancer Teams: Findings of a National Study

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ABSTRACT

Background. Multidisciplinary teams (MDTs) are the standard means of making clinical decisions in surgical oncology. The aim of this study was to explore the views of MDT members regarding contribution to the MDT, representation of patients' views, and dealing with disagreements in MDT meetings—issues that affect clinical decision making, but have not previously been addressed.

Methods. Responses to open questions from a 2009 national survey of MDT members about effective MDT working in the United Kingdom were analyzed for content. Emergent themes were identified and tabulated, and verbatim quotes were extracted to validate and illustrate themes.

Results. Free-text responses from 1,636 MDT members were analyzed. Key themes were: (1) the importance of nontechnical skills, organizational support, and good relationships between team members for effective teamworking; (2) recording of disagreements (potentially sharing them with patients) and the importance of patient-centered information in relation to team decision making; (3) the central role of clinical nurse specialists as the patient's advocates, complementing the role of physicians in relation to patient centeredness.

Conclusions. Developing team members' nontechnical skills and providing organizational support are necessary to

help ensure that MDTs are delivering high-quality, patient-centered care. Recording dissent in decision making within the MDT is an important element, which should be defined further. The question of how best to represent the patient in MDT meetings also requires further exploration.

In many countries, including the United Kingdom, Australia, the United States, Canada, and Hong Kong the preferred method of delivering cancer care is by multidisciplinary care teams (MDTs).^{1–5} Composed of surgeons, clinical and medical oncologists, specialist nurses, radiologists, pathologists, and others, such teams operate along the whole care pathway from diagnosis to follow-up and beyond.¹ In the United Kingdom, MDTs are mandatory, having first been introduced to standardize cancer care by ensuring that patients receive timely and appropriate care from skilled professionals.⁶ A focal aspect of the MDTs is the MDT meeting, which in the United Kingdom typically occurs once a week.¹ Patients can be discussed at the MDT meeting at any point along the treatment pathway, although typically this occurs at diagnosis, following treatment, and sometimes if there is a recurrence or progression of the disease. The key task of the team during a MDT meeting, often under the leadership of a surgical oncologist, is to collate and review information about the patient and their disease, discuss it, and make a decision for further investigation and treatment.^{7,8}

The quality of clinical decision making in MDT meetings depends on comprehensive consideration of information about the disease, as well as information on patient preferences and comorbidities in an open and

inclusive discussion process.⁸ Evidence shows that MDTs can bring about improvements in clinical care by consensual team decision making, good team working, and increased adherence to clinical practice guidelines.^{9–11} There is also evidence that decisions that take into account patients' preferences, performance status, and comorbid health conditions are more likely to be implemented as these decisions are more likely to be clinically appropriate and acceptable to patients.^{12,13} While having patients present at the MDT meeting might allow such information to be readily incorporated into the decision-making process, the practical difficulties of such an arrangement mean that in the United Kingdom patients do not attend MDT discussions (and it has also been argued that presence of the patient in the MDT may adversely affect the quality of the discussion).¹⁴ In the absence of the patient, in order to ensure decisions are acceptable to patients their interests must be well represented in meetings—through open and equal discussion.⁸ However, high-quality evidence of improved clinical outcomes is lacking (though emerging), and the process of clinical decision making remains variable across different MDTs.^{8,15–17}

In particular, a number of questions remain regarding MDT functioning, which have not been addressed to date. These include issues such as how best to represent patients' views in MDT meetings, how disagreements within the team should be dealt with, and what are the factors that facilitate participation in the clinical decision-making process in these meetings, including organizational factors (e.g., lack of time to prepare or attend the meeting) or more interpersonal factors (e.g., steep hierarchies, lack of trust or respect between team members). These issues can affect directly the process by which a MDT makes clinical decisions and may contribute to some of the variability seen in MDT performance.^{8,18} Indeed, adequate sharing of clinical information between medical team members and the presence of dissent have been shown to improve decision making in psychological experiments on teams.^{19–21} Further, psychological research has also shown that information that is shared is more likely to be discussed and to be part of the decision-making process and that team members of higher professional status tend to have a significantly stronger role and say in the team's decisions, thus making team leadership and meeting chairing critically important to cancer MDTs.^{22,23}

This psychological research, however, has yet to be translated into the field of cancer MDT working, and there is currently no consensus regarding best practice in these areas. Therefore, addressing some of these issues may provide evidence on which MDTs can develop their practice. In the absence of strong evidence regarding which characteristics of MDT working improve clinical outcomes, the United Kingdom's National Cancer Action

Team (NCAT) recently conducted a national survey of MDT members' perceptions of MDT working.^{24,25} In the absence of evidence from empirical trials, such an assessment of current practice can contribute to a benchmark against which MDTs can appraise and develop their practice. More than 2000 MDT members responded to the survey. Responses to multiple choice and scale items have been reported previously with more than 90 % of respondents in agreement that an effective MDT results in improved clinical decision making, more coordinated patient care, improvement in overall quality of care, more evidence-based treatment decisions, and improved treatment.²⁴ In addition to scaled items, this national survey included free-text responses, where participants could report their own views and perceptions on their MDTs. Systematic and scientific analysis of responses to these questions has not yet been undertaken. Finding what is important to MDT members in relation to how their teams actually function and how they make patient-centered decisions may help to define team standards that could then be used to augment current team assessment methods, which do not address such issues (e.g., the "peer review" process in the United Kingdom).^{1,26}

The study that we report here analyzed these free-text responses, aiming to define effective teamworking in MDTs, the efficacy of decision making by MDTs, and patient centeredness of the MDT decision-making process—all of these with particular reference to similarities and differences in views between different "core" professional groups.

METHODS

The 2009 National Cancer Action Team Survey

The 2009 U.K. survey aimed to investigate MDT members' perceptions about effective MDT working, including aspects of the structure, resources, and process of decision making within cancer MDTs. It was designed by a steering group consisting of 32 cancer professionals, with representation from all core disciplines in cancer MDTs, including surgeons, physicians, clinical and medical oncologists, clinical nurse specialists, various allied healthcare professionals, and administrators (known as "MDT coordinators" in the United Kingdom), ensuring face and content validity. Surveys were completed online between January 30 and March 16, 2009. Survey participants were recruited from across the United Kingdom via cancer networks, cancer service managers, the MDT coordinators' forum, and the Network Development Program forum for Informatics. A link to the survey was also provided on the National Cancer Intelligence Network website. Participants were sent an introductory e-mail with the web address of the survey, and a snowball sampling method was used with participants

encouraged to circulate the details broadly among other MDT members. Anonymity was ensured, and informed consent implied by completion of the survey.²⁴

Analyses of the “closed” (Likert scale and multiple choice) survey questions, which addressed other issues, are reported elsewhere.^{24,25} This study focuses on 6 free-text items of the survey that specifically address the issues of teamworking and team decision making in MDTs. The raw data for these items are publicly available (http://www.ncin.org.uk/cancer_type_and_topic_specific_work/multi_disciplinary_teams/MDT_development.aspx), but are yet to be analyzed scientifically. These 6 questions cover 3 categories:

- Effective teamworking in MDT meetings:
 - Q1: What makes a MDT work well together?
 - Q2: What would help you to improve your personal contribution to the MDT?
- Efficacy of MDT decision making:
 - Q3: How should disagreements/split decisions over treatment recommendations be recorded?
 - Q4: What are the main reasons for MDT treatment recommendations not being implemented?
- Patient centeredness of the MDT decision making process:
 - Q5: Who is the best person to represent the patient’s views at a MDT meeting?
 - Q6: Who should be responsible for communicating the treatment recommendations to the patient?

Data Analysis

A total of 2054 MDT members responded to the survey. For the purposes of the analysis, respondents were grouped into 3 categories: doctors (D), nurses along with allied healthcare professionals (N), and then MDT coordinators and nonclinical personnel (C). The analytical approach followed established standards in qualitative research to ensure validity and transparency.²⁷ First, all open-ended responses to the survey were collated into a single document to form a transcript. These transcripts were then analyzed independently by 2 blinded coders (J.N.L. and S.S.). The coders aimed to extract from the transcripts “themes” in relation to each 1 of the 6 open-ended questions and to allocate all of participants’ responses to these themes. Given the large number of respondents to the survey, reliability of theme coding was examined statistically using Spearman rho correlations (to ensure the 2 coders extracted similar number of themes). A sample (20 %) of the responses to each question was coded

independently by another member of the research team with expertise in qualitative methodology (B.L.) to further ensure quality control and reliability of theme extraction.

Once extracted, the emergent themes were discussed between the coders and 2 senior members of the research team who had been kept blinded to the themes and did not have access to the data during the coding phase, 1 with background in surgical oncology (J.G.) and 1 with background in psychology (N.S.). Themes were finalized at this stage, themes were tabulated, and verbatim quotes from respondents to validate and illustrate the themes were extracted. To simplify, presentation themes reported by a very small minority of respondents (fewer than 5 % of the total) are not presented in this paper, but are available from the corresponding author.

RESULTS

Respondents

Of 2054 respondents to the NCAT survey, 1636 answered at least 1 of the questions included in this analysis, including 875 doctors (80 % of the total number of doctors who participated in the survey), 502 nurses and allied healthcare professionals (81 % of the total number of nurses and allied healthcare professionals who participated in the survey), and 260 MDT coordinators and other non-clinical MDT members (76 % of the total number of MDT coordinators and other nonclinical MDT members who participated in the survey). The total numbers of respondents answering individual questions were: Q1, $N = 867$; Q2, $N = 653$; Q3, $N = 810$; Q4, $N = 941$; Q5, $N = 1304$; and Q6, $N = 1312$. The range of responses across all 6 questions by professional group (min–max number of respondents) was 369–689 for doctors, 191–421 for nurses/allied health professionals, and 93–202 for coordinators/nonclinical personnel. These response rates are unusually high in qualitative research of the type reported here and ensure adequate “theme saturation,” in other words, adequate coverage of the key themes per question as required in qualitative research.²⁷

Key Themes

Tables 1, 2 and 3 display detailed results for each of the questions across the 3 areas of interest, namely teamworking in MDTs (Table 1), team decision making in MDTs (Table 2), and patient centeredness of the decision-making process (Table 3). The tables include the most prevalent themes in descending order, the proportion of responses that fell within each of them (%), and verbatim quotes to illustrate theme content. Spearman rho coefficients between the

number of themes extracted by the 2 coders were all positive and significant ranging from 0.651 to 0.844 for the included questions ($P < 0.001$). This indicates good reliability in the coding.

Effective Teamworking (Q1 and Q2) MDT members recognized the need for adequate “nontechnical” skills to ensure MDT meetings function well. These are interpersonal and behavioral skills that complement clinical skills and competencies, including mutual respect, good communication, and good leadership (Table 1, see Q1).²⁸ Equally, institutional support from the hospital for the work of the MDT emerged as a key requirement, particularly among doctors, including an acknowledgement by hospital management of the workload generated for team members by premeeting preparation as well as taking action on the outcomes of the MDT meeting and the provision of adequate time in meetings to ensure that case discussions are not rushed (Table 1, see Q2). MDT coordinators/nonclinical personnel were less likely than either doctors or nurses to want more time for MDT working, but more likely to suggest that

educational training days would improve their contribution, thereby revealing an existing training need for this group.

Efficacy of Decision Making by MDTs (Q3 and Q4) Participants recognized that disagreements within the team do occur, and the consensus across all of them was that such disagreements ought to be recorded. Doctors were overall more likely to suggest verbatim recording, whereas nurses and coordinators were of the view that noting disagreements in meeting minutes is sufficient. Acknowledgment of such disagreements within patient notes and also in discussions with patients also surfaced as potentially useful aspects for handling disagreements (Table 2, see Q3). Regarding lack of implementation of MDT decisions, lack of information derived from close contact with patients was reported as the main reason for decisions not being implemented (Table 2, see Q4). Interestingly, a smaller proportion of doctors than nurses or MDT coordinators responded that a direct lack of patient contact is the main reason behind nonimplementation.

Patient Centeredness of the MDT Decision-Making Process (Q5 and Q6) Consensus emerged regarding

TABLE 1 Responses related to effective team working in MDT meetings (questions 1 and 2)

Rank	Themes	% Response				Quotes
		D	N	C	Total	
Q1: What makes an MDT work well together?						
1	Mutual respect and understanding	50	64	44	54	“People are valued and their opinions taken seriously and considered.” (N)
2	Enthusiasm & positivity	22	14	27	21	“Enthusiasm, dedication, and hard work.” (C)
3	Good communication	11	29	29	21	“On some occasions there has been difference of opinions but by good communications it is worked out.” (C)
4	Sharing of common goals	20	14	7	16	“A clear operational policy which has been constructed with involvement from core members thus promoting shared common goals.” (D)
5	Good leadership	11	12	8	11	“The Chair should endeavor to control controversy, and try and resolve problems.” (N)
6	Patient centeredness	5	6	8	6	“All members here tend to focus on the patient’s welfare and agree on the best pathway for each patient.” (C)
	Number of respondents:	434	292	153	867	
Q2: What would help you to improve your personal contribution to the MDT?						
1	Time recognized in job-plan to attend	29	18	8	23	“More time for MDT’s—at present they are over lunchtime on a Friday, we have no radiology or histology staff.” (N)
2	Educational training days	7	14	39	14	“Access to training within a multi-professional team, done as an MDT team.” (N)
3	More time in meetings	19	3	0	11	“There are many issues that could be discussed at our MDT but there is no time.” (D)
4	Time to prepare for meetings	14	10	2	11	“More preparation time recognized in my job plan. More support from my department in recognizing the importance of the MDTs.” (D)
5	Organizational support	10	11	15	11	“More support from line managers who don’t seem to have a basic understanding of the demands of the role.” (C)
6	Stimulation by other team members	2	17	8	7	“We are a functional team and actively stimulate each other to work better.” (N)
	Number of respondents:	369	191	93	653	

D doctor, N nurse/allied health professional, C coordinator/nonclinical personnel

TABLE 2 Responses related to team decision making in MDT meetings (questions 3 and 4)

Rank	Themes	% Response				Quotes
		D	N	C	Total	
Q3: How should disagreements/split decisions over treatment recommendations be recorded?						
1	Record (not specified)	91	85	83	88	
2	Document verbatim	43	26	20	35	“[Record] who recommended what and why. It is not appropriate to think of it as a ‘majority verdict’ as this does not necessarily reflect evidence base.” (D)
3	Write in minutes of meeting	19	44	45	30	“[Record] within MDT minutes and patient records.” (N)
4	Write in case notes	10	26	10	15	“Entered into notes via an MDT letter to the GP or referring clinician.” (C)
5	Tell patient about disagreement	17	14	8	15	“Both decisions should be recorded on the MDT outcome forms and then discussed with the patient along with the reasons why decisions were split.” (N)
6	Record a consensus	9	5	7	8	“A consensus should always be aimed for, and in the rare event that there is significant dissent, the alternative treatment discussed should also be recorded if possible.” (D)
	Number of respondents:	454	239	117	810	
Q4: What are the main reasons for MDT treatment recommendations not being implemented?						
1	Lack of knowledge of patient’s views	53	40	35	47	“The patients’ preferences. Sometimes patients are discussed prior to being seen and when reviewed the patient has different wishes.” (N)
2	Lack of personal contact with patient	6	64	58	30	“You cannot make a firm recommendation in many circumstances without seeing the patient yourself to assess the appropriateness of the treatment.” (D)
3	Changing clinical picture	19	3	4	12	“A patient’s condition may deteriorate soon after the MDT and require emergency intervention by surgery or other treatment.” (D)
4	Lack of knowledge of patient comorbidities	17	4	3	11	“Performance status stopping someone being fit for the treatment and this info not available at MDT.” (N)
5	Incorrect clinical information	14	3	2	9	“If the incorrect information about the patient’s history was communicated at the MDT it changes what treatment they [the patient] could or could not have.” (C)
	Number of respondents:	539	273	130	941	

D doctor, *N* nurse/allied health professional, *C* coordinator/nonclinical personnel

TABLE 3 Responses related to team decision making in MDT meetings (questions 5 and 6)

Rank	Themes	% Response				Quotes
		D	N	C	Total	
Q5: Who is the best person to represent the patient’s views at an MDT meeting?						
1	Clinical nurse specialist	68	55	65	63	“The specialist nurse as they work closely with the patient and the patient’s family and form a relationship.” (C)
2	Consultant in charge	51	22	41	40	“Ideally the physician with responsibility for their care.” (D)
3	Whoever knows the patient best	36	37	17	33	“Variable, dependent on individual who knows the patient the best.” (D)
4	Key worker (other)	16	15	9	15	“Key worker or clinician who has had direct contact with the patient.” (N)
Number of respondents:		682	420	202	1304	
Q6: Who should be responsible for communicating the treatment recommendations to the patient?						
1	Consultant in charge	68	68	75	69	“The consultant who the patient is under the care of at the time of the management decision of the MDT.” (C)
2	Clinical nurse specialist	33	49	51	41	“For some patients this information may be appropriately communicated by a specialist nurse.” (D)
3	Key worker (other)	6	14	6	9	“Whoever is delegated as the key worker.” (N)
4	Whoever knows the patient best	7	8	3	7	“Whoever has had most meaningful contact—medic or nurse—may be different for different people.” (N)
Number of respondents:		689	421	202	1312	

D doctor, *N* nurse/allied health professional, *C* coordinator/nonclinical personnel

who within the MDT is the key patient contact, with clinical nurse specialists and consultants/attending doctors both cited most frequently. The view that whoever in the team knows the patient best, however, was also prominent (Table 3, see Q5). Respondents' views were equally consensual regarding which MDT member should be communicating the team recommendation to the patient: the consultant/attending physician in charge and the clinical nurse specialist emerged as the key members to carry out this task (Table 3; see Q6).

DISCUSSION

We have analyzed comments provided by a nationally representative sample of more than 1600 MDT members regarding effective teamworking in MDTs, efficacy of decision making by MDTs, and patient centeredness of the MDT decision-making process. To the best of our knowledge, this is the largest sample to be collected for this type of qualitative analysis to date, not just within the United Kingdom, but internationally. The key themes that emerged in relation to effective teamworking were the importance of good relationships between team members, adequate nontechnical skills (i.e., communication, leadership), and the need for support at an organizational level. In relation to team decision making, recording of disagreements when they occur (and potentially letting the patient know) and the importance of having adequate information about the patient were key emerging issues. Finally, in relation to patient centeredness of MDT decision making the key role of the clinical nurse specialists as patient advocates alongside the medical personnel and the complementary role of nurses and consultants/attendings in discussing team recommendations with the patient were key findings.

A number of implications emerge from these findings in relation to how MDT meetings are carried out. A first important issue is who should represent the patient and their interests in the MDT. It is usually assumed that nurses, by virtue of their skill in gathering and assimilating patient-centered information into decisions, should play a central role in clinical decision making at the MDT meeting.^{12,29–34} The present study provides persuasive evidence that patients should only be represented by team members who know them well. The results suggest that the clinical nurse specialist is the preferred team member to represent the patient in meetings, but that the consultant/attending surgeon and other team members could also share this duty. While having the patient present in the MDT would undoubtedly inhibit discussion in many cases, a patient discussion with 1 or 2 MDT members could follow the main MDT meeting. Interest in shared decision

making between clinicians and patients is increasing. Projects such as those at the Center for Informed Choice at the Dartmouth Institute, NH, and “MAKING Good decisions In Collaboration with patients” (MAGIC) in the United Kingdom have helped to increase the understanding of healthcare providers and policy makers on how best to engage patients in clinical decision making.^{35,36} Overall, however, patient preferences can be volatile, and little is known about how patients want their needs and preferences to be represented in MDT meetings, which are important issues requiring further exploration.³⁷

Another emerging issue is that nontechnical skills are necessary for smooth, effective MDT functioning. These skills, including communicating effectively with colleagues at various levels of hierarchy and managing conflict within teams, are being increasingly recognized as key contributors to safe, high-quality care delivery across medical and surgical specialties.^{8,38–40} It follows that assessing the quality of teamworking in MDTs is a step to be taken in the future and for that transparent, feasible, and valid tools are required. With this objective in mind, our research group has recently developed the “MDT MODE” tool (Metric for the Observation of Decision-making) that enables MDTs to assess their own teamworking and clinical decision making through external as well as self-assessment. Through a rigorous scientific development process, MDT MODE has been shown to be valid, feasible, and based on current best evidence.^{41,42}

This study also reveals that although adequate nontechnical skills are necessary for optimal MDT functioning, on their own they are not sufficient. Support from the hosting institution (i.e., the local hospital) is also required in the form of protected time in the participants' job plans to prepare for, attend, and take action on the workload of the meeting. This finding corroborates recent research evidence from our group that found that team members without protected time for meetings were less likely to attend meetings and that the most frequently cited organizational improvement to MDT working was more time dedicated to MDT working.⁴³

Recognition that a lack of patient-centered information presents a barrier to decision making adds to a small but expanding evidence base that shows that failure to consider comprehensively patient-centered information inhibits decision making, renders decisions clinically inappropriate or unacceptable to patients, and therefore impairs the entire decision-making process.^{12,13,44,45} The question of how best to bring patient preferences and values into the MDT is a complex one. First, the importance of patient preferences will vary according to the disease itself and the personal values and circumstances of the patient. Second, it is not clear whether it is in the patient's best interests that their preferences form part of the decision-making process

or whether the team should initially discuss clinical options before patient preferences are considered. Patients themselves might have a range of different views on this issue. Third, preferences patients express before the full MDT meeting might change according to the advice and reflections emanating from the meeting.

Our finding that MDT members recognize that disagreements should be recorded and can be discussed with the patients is reassuring and requires further investigation. The subject of disagreement and dissent has not received much attention previously. In a study of attending-level MDT members in Australia, participants reported an “open” culture for discussion in their MDT environments. Disagreements within MDTs were uncommon, and team members described reluctance to “formally” dissent. However, more than half of participants were unaware of their individual liability for the decisions made in MDT meetings at which they were participants.⁴⁶ From a team psychology perspective, dissent is not detrimental to a team; in contrast, teams where no one ever dissents are at risk of “false consensus” or “group-think” biases, where dissent exists but it is never openly expressed.^{23,47} Such attitudes may indicate lack of open communication within the team and have been shown to lead to poor decision making.^{22,23,48} Within a MDT, ensuring open communication where dissent is acknowledged and managing dissent are key elements of the lead’s or chair’s role; we believe further research should be carried out to evaluate how often and where dissent occurs in MDTs and how it should be managed.

Certain limitations must be applied to our findings. The study relies on self-report and qualitative analyses, which may affect generalizability. In addition, the method used to recruit the survey sample involved snowballing; so it is not possible to be certain of the response rate or how representative the sample is of the population of MDT members as a whole. Moreover, the total number of participants (to the survey and also to the free-text questions reported here) is certainly only a fraction of the thousands of healthcare professionals working in the 1500 MDTs in the United Kingdom and may favor those with a propensity to respond to such a survey. Furthermore, the availability of demographic data on participants is limited. Taken together, these limitations could limit the generalizability of the findings. However, an increasing number of studies of various methods have started to appear in the literature, that reveal results similar to ours.^{43,49,50} Our sampling was successful in representing respondents across core MDT members, from a wide range of geographical locations throughout the United Kingdom. International differences between cancer MDTs in the United Kingdom (which are mandatory) and the optional MDTs that operate in other countries, in particular the United States, mean that the findings of the study may not be generalizable to healthcare

systems in other countries. This may be particularly pertinent concerning organizational factors that are likely to be locally different. Again, however, some of the issues revealed here (e.g., team skills, team members to communicate with patients) are indeed found in other countries outside the United Kingdom and are increasingly reported in the literature.^{49,50} The current process of MDT assessment used in the United Kingdom is focused on ensuring that MDTs meet certain standards of service organization, with little attention to the process of clinical decision making in the MDT meeting. MDTs are required to collect data on their performance on a large number of measures, ranging from team composition and delegated responsibilities to compliance with targets for the time taken to diagnose and treat patients. This data is then subjected to an external audit by members of other, unrelated MDTs, often on an annual basis.¹ The findings of this study, when taken together with recent quantitative survey findings from U.K. MDT members, provide a consensus that could be used as evidence to set standards for teamworking and patient-centered decision making.^{24,25} For example, (1) when disagreement arises in the MDT meeting, the nature of the disagreement and which members are disagreeing must be recorded in the MDT record and (2) the disagreement that arose should be made known to the patient and the patient should be supported to make a decision based on these differing recommendations.

We believe that combined with the current assessment process such standards would help to ensure that the process of MDT assessment is more focused on the characteristics of a highly functioning MDT associated with high levels of patient-centered clinical decision making. Continuing research is needed to further allow assessment of teamworking and team decision making in MDTs (like MDT MODE), so that teams are able to assess their own performance in these areas, making improvements where necessary.^{41,42}

This study provides evidence for what U.K. MDT members consider to be elements of good teamworking and patient centeredness in clinical decision making by MDTs. It reveals the importance of team members’ skills, as well as organizational support in having well-functioning teams that make recommendations for their patients that are implementable. The study strengthens the currently emerging impetus in the international literature for robust assessment of team functioning in healthcare and also offers for the first time a consensual approach on how to record disagreements within cancer MDTs. We have recently developed and evaluated a checklist with the aim of improving decision making in MDT meetings (MDT QuIC).⁵¹ Such a tool allows for a streamlined discussion and may also provide the opportunity to formalize disagreement and dissent, as well as increase the transparency of the MDT’s decision.

Psychological research on team decision making shows that it can be improved by some level of standardization that ensures all issues are addressed, team members feel psychologically “safe” within the team, the impact of hierarchy is controlled, and a shared view of the task and each other’s roles are held within the team.^{22,23} Clinical evidence also shows that such approaches do improve shared understanding within clinical teams and their performance.⁵² As a minimum, we believe the process of recording MDT outcomes, particularly when disagreement arises, should be defined and guidance offered to MDT members. Further research should address the question of how best to represent the patient’s preferences in MDT decision making, with the view to make MDT-driven care even more patient centered.

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