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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,¹ there is a lack of existing literature internationally that describes the structure and function of palliative care MDTMs.² MDTMs exist to ensure collaboration across professions

Key messages

What was already known?

- ▶ Multidisciplinary team meetings are a recognised component of palliative care as well as in a range of other care settings (eg, cancer).
- ▶ The meetings provide an opportunity to coordinate multiple clinical and social services that might be relevant for complex patient needs.
- ▶ Multidisciplinary team meetings enable palliative care teams to report patient deaths and offer an opportunity to discuss matters that are currently unclear or unresolved.

What are the new findings?

- ▶ While the many practical, clinical and social support elements that inform decision-making are formally recorded, the meetings also enable staff members to share and negotiate the negative affective dimensions of their work.
- ▶ While these aspects are not formally documented, their acknowledgement helps support individual staff members and consolidate the team.

What is their significance?

- Clinical: it may be tempting to undervalue the role of regular meetings, especially when no major new decisions are made, and when there are increasing resource pressures put on the team. However, recognising some of the less tangible aspects is crucial—not only for the ongoing welfare of staff but also indirectly as a means to protect and conserve the emotional dimensions of caring for people who are ill and/or dying.
- Research: more thorough and detailed qualitative research into this topic is likely to reveal further related aspects of these meetings, including the dynamic nature of individual and collective decision-making and processes of sharing emotional burdens.

(medical, nursing, occupational therapy, physiotherapy, social work and spiritual care),³ although the composition often varies. Meetings can include patient case discussions, decision-making, education and research.⁴ Over the years, MDTMs within palliative care have evolved, as teams draw on them for different purposes while increasingly working under system constraints. Against this background, we describe and analyse the MDTMs of a hospital and a community-based palliative 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.^{5 6} 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.⁷ 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 V.12 and analysed by the research team in two parallel operations. 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.⁸ 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, bereavement 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 electronic 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 information (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 electronic 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 that 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 potential 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 care¹⁰; they provide attendees with the opportunity to gain awareness and appreciation of views central to different professions.¹¹ Professionals find them useful, providing a comprehensive approach to care viewed

as integral to palliative care,¹² even though there is complexity in the communication during meeting¹² and meetings can be time-consuming.¹³

Although the effectiveness of MDTMs is regularly considered,¹⁴ 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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