

Multidisciplinary team members views about MDT working:

**Results from a survey commissioned by
the National Cancer Action Team**

Open question responses: Oncologists

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Introduction

This report provides the responses given by **oncologists** to the open questions within an on-line survey commissioned by the National Cancer Action Team and undertaken by Business Boffins Ltd. The survey aimed to assess multidisciplinary team (MDT) members' perceptions regarding: what parameters are essential for an effective MDT, how best to measure MDT effectiveness, and what support or tools MDTs may need to become or remain effective.

For full details regarding the methods and procedure of the survey, please see the final report issued in October 2009: <http://www.ncin.org.uk/mdt>

Open questions

In total, the survey contained 21 free-text (open) questions covering the following aspects of MDT working (*question shown in italics*):

1. Domains that are important for effective MDT working

What do you think constitutes an effective MDT?

- The Team
 - Leadership
 - *What qualities make a good MDT chair/leader?*
 - *What types of training do MDT leaders require?*
 - Teamworking
 - *What makes an MDT work well together?*
- Infrastructure for meetings
 - Physical environment of the meeting venue
 - *What is the key physical barrier to an MDT working effectively?*
 - Technology (availability and use)
 - *What impact (positive or negative) does teleconferencing/video-conferencing have on an MDT meeting?*
 - *What additional technology do you think could enhance MDT effectiveness?*
- Meeting organisation and logistics
 - Preparation for MDT meetings
 - *What preparation needs to take place in advance for the MDT meeting to run effectively?*
 - Organisation/administration during MDT meetings
 - *What makes an MDT meeting run effectively?*
- Clinical decision-making
 - Case management and clinical decision-making process
 - *What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at an MDT?*
 - *What are the main reasons for MDT treatment recommendations not being implemented?*
 - *How can we best ensure that all new cancer cases are referred to an MDT?*
 - *How should disagreements/split-decisions over treatment recommendations be recorded?*
 - Patient-centred care/coordination of service
 - *Who is the best person to represent the patient's view at an MDT meeting?*

- *Who should be responsible for communicating the treatment recommendations to the patient?*

2. Measuring MDT effectiveness/performance

- *What other measures could be used to evaluate MDT performance?*

3. Supporting MDTs to work effectively

- *What one thing would you change to make your MDT more effective?*
- *What would help you to improve your personal contribution to the MDT?*
- *What other types of training or tools would you find useful as an individual or team to support effective MDT working?*
- *Please provide details of training courses or tools you are aware of that support MDT development.*

4. Final comments

- *Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance.*

The responses to each question have been compiled into reports according to each discipline, as follows:

Professional Group	Discipline	Total number of respondents to survey
Doctors	Surgeons	325
	Radiologists	127
	Histo/cytopathologists	126
	Oncologists (clinical and medical)	164
	Haematologists	98
	Palliative care specialists	65
	Other doctors (e.g. physicians, GP)	188
Nurses	Clinical nurse specialists and other nurses (e.g. nurse consultants, matrons, ward nurses etc)	532
Allied Health Professionals	Allied Health Professionals	85
MDT coordinators	MDT coordinators	302
Other (admin/clerical and managerial)	Other (admin/clerical and managerial)	42
Total number of MDT members who responded to the survey		2054

Method

- The total number of respondents from each discipline is shown in the table above.
- The number of respondents who responded to each question is provided at the start of each question.
- All written responses are presented in an unedited form, exactly as given by respondents (including any typographic errors, spelling mistakes, use of capitalisation etc). Exceptions to this are:

- a. Where respondents did not provide an answer to a question but instead used a symbol (e.g. /) to indicate that they wanted to miss out the question. Such responses have not been included.
- b. Where respondents used free-text questions to simply refer to the previous (multiple choice) question (e.g. 'see above' or 'as above'). Such responses are removed due to the lack of context provided by including these in this report but a total count of such responses is provided in the summary at the start of each question.
- c. Where respondents have named an organisation or Trust or potentially identified themselves. Their responses have been anonymised.
- d. Where respondents used potentially offensive language. Any such words have been replaced with xxxx.
- e. If respondents have given comments that are not relevant to the question. Such comments have been removed from the response.

Responses to 3 of the open questions have been fully analysed to-date and results are provided in the final report issued in October 2009. These are:

- *What do you think constitutes an effective MDT?*
- *What qualities make a good MDT chair/leader?*
- *What one thing would you change to make your MDT more effective?*

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Domains that are important for effective MDT functioning

What do you think constitutes an effective MDT?

127 oncologists responded to this question.

1. working equipment, all relevant info available to make safe and appropriate decision for patient
2. Well organised ensuring relevant patients are discussed together with their histology and imaging. All members prepared to contribute their views.
3. well co-ordinated team that has good lines of communication; adequate information (particularly history) presented and clarity of what question is being asked; opportunity for members to express their opinion; clear record of minutes - with what being recorded representative of discussion had; adequate time;
4. Well chaired meeting. Discussion led by professional who KNOWS the patient and can aid assessment of potential treatments. Clear goals for the MDT set with all relevant information (clinical, radiology, pathology etc) available for discussion
5. weekly, truly multidisciplinary, quorate, good chair and effective co-ordination.
6. There needs to be a clear co-ordination between the members and clear information from the referrals. There needs to be flexibility from the core members depending upon the clinical situation.
7. The role of co-ordinator and data manager is crucial to the effectiveness of the MDT. Without her it would be a huge headache.
8. the effect should be to improve patients access to the most appropriate care the information needed is 1- patient factors; age, comorbidity, performance status (which are significantly unrelated to require all for decisions) 2 - TUMOUR FACTORS; TYPE, STAGE, GRADE 3 - treatment factors; what has been done so far most MDTs access well the last 2 factors but almost never the first one in any validated way.
9. teamwork and getting on with colleagues
10. Team working, organisation, focused discussion
11. team working and respect, but effective chairing
12. Team work. An environment that facilitates thorough discussion of each case where individuals feel they can give their opinions without being belittled by the few bullies that exist in some MDTs.
13. Structured, full patient information available, organised, interactive, effective documentation of outcome and reasons for outcome
14. Strong leadership, clinical respect for others' opinions, a team who genuinely have the patient as the centre of their focus
15. someone who can move the discussion on A chairman who is prepared to act as a devils advocate when required Outcome data would be informative but rarely available Clinical nurse specialists who know the patient Doctors who have ACTUALLY seen the patient and can provide useful clinical information
16. Right people Strong leadership Access to all relevant information
17. Requires optimum collection of clinical information, quality media presentation, appropriate attendance and adequate time
18. representation from diagnostic and treatment teams including physicians, surgeons, specialist nurses regular meeting administrative support resources IT, room education - regular meeting regular development meeting audit
19. representation from all specialities regular meeting full access to investigations including scans not just reports clear data collection to facilitate research and audit decision dissemination to facilitate clinical decision making in the clinic - this needs to be available both in cancer centres and the cancer units being served by the centre and to GPs appropriate time allocation in job plans and financial backing for adequate facilities by management. representation by management at development meetings education input
20. Regular attendance by core members and if unable to attend a substitute sent. Discussion of cases needs to be carried out in a constructive and cordial way

even if there are differences of opinion so that everyone feels able to contribute
MDT co-ordinator is essential. Suitable location with access to projector so that
imaging and pathology can be reviewed and the room should be large enough to
comfortable accommodate all the attendees. Outcomes from MDTs stored centrally
on computer so can be accessed by all members as needed and a copy to go into
the notes

21. regular attendance by core members
22. Regular attendance of core members MDT support coordinators to prepare notes
etc data recorder to complete proformas
23. regular attendance by representatives of all specialties involved, good
communication of outcomes, contribution by members at all levels of seniority
24. regular attendance by core members. timely access to all data (path, imaging)
25. Regular attendance by all core members. Weekly meeting to discuss all cases.
Good chair. Access to all relevant information on the day. Consistent clear
decision making/recommendations according to agreed protocols. Well resourced:
co-ordinator, data manager, quality projection/video conference equipment if
required.
26. Regular and frequent attendance by core members. Availability of necessary
information. Tightly chaired. Egos under control (self-control preferred but force
majeure occasionally necessary) Supply of fresh air in the room (sounds trivial
but actually very important) Adequate equipment and space. Discussion of trial
and standard options for all patients. MDT results made available in the notes
(not e-mailed round as this is of little use to people who routinely get >100
messages daily)
27. re meetings..good chair, attendance of key members, enough time, radiologists
and pathologists who regard themselves as key participants in the patient
management, a good coordinator who can take responsibility, efficient transfer
images/ path etc, good relationships between members,
28. Radiology/oncology/pathology/surgery/physician +/- research nurse and palliative
care High level of expertise AND the capacity to discuss ie talk and listen
29. Punctuality, presence of all key people, availability of all relevant radiology and
histopathology, tight chairing, appropriately detailed summaries of complex cases
(agreed at the meeting)
30. Presence of appropriate core staff (Oncologist, radiologist, pathologist, surgeon or
physician, specialist nurses, coordinator), ready access to radiology - not always
available with poor IT technology, ability to upload Cancer Register at MDT and
check input. Record of MDT decision readily available. Too many patients on MDT
overloads and reduces efficiency
31. Presence of all core member, good chair, open discussion
32. organised team that can discuss at pt fully. I find that sometimes although the
path and radio might be present the actual PS etc are not known!
33. organised agenda, clinical notes to hand, efficient recording and filing of
discussions into notes, with dissemination to appropriate professionals
34. Organised (scans and clinical info available). Well-chaired. Open discussion.
Colleagues keen to learn from each other. Adverse events analysed to learn
lessons / improve service. Decisions recorded accurately
35. Openness, Team & patient focus, Ability of all to challenge & to get a fair hearing.
Good information & record keeping
36. One where decisions are made, recorded and the all members feel that the best
interests of the patients are being served
37. one where all the relevant people are there on a regular basis and on time - where
the relevant and correct details are available to discuss patients and the results in
an efficient manner in which to arrive at a management plan which can be
discussed with the patient and their relatives as soon after this discussion has
taken place. Everyone involved in the MDT needs to have an interest in the
particular patient group being discussed, ensure they are up to date with regards
to evidence base for their management of the particular cancer site and be able to
actively participate in the discussion.
38. One that, in addition to making the necessary decisions, provides an educational

environment

39. One that meets regularly, say weekly; core members should attend or provide a stand in. Relevant information should be gathered to be presentable for the core members (MDT coordinator) has an effective chairperson who ensures that discussion is relevant, brief if possible and reaches a conclusion, which is stated and recorded, so that dissemination is then possible ie to GP's etc. Also enabling data collection. Preferable: Good atmosphere, pleasant members, quick, proper time allocated in job plan.
40. one that makes correct clinical decisions
41. One that is efficient, makes sensible decisions and doesn't waste too much health professional's time
42. One in which -all relevant information is available for each patient -the focus is on clinical decision making for patients -'routine' cases are rapidly dealt with - difficult cases have time to be properly discussed
43. no one team or member dominating decisions
44. need members of all specialties present. clinician who has assessed pt should be the one presenting the patient. question being asked should be clear
45. mutual trust & respect , no dominant personality , adequate administrative support , acceptance if following protocols that have been agreed mdt acts more as an audit leaving the difficult cases time for adequate discussion.
46. Must last no longer than 1 hour. A patient should only ever be presented a maximum of twice per major intervention. Leading consultants with research interests must lead
47. Multidisciplinary decision making at key points in a patient's management, accessible records
48. Multi disciplinary team with time and resource to fully discuss cases
49. Meeting of minds. Multiprofessional opinion of patient care all at once, under one roof, to provide best practice and expediency in relation to diagnosis and treatment.
50. like minded clinicians all working together for the best service to be given to the patient
51. Leadership Role responsibility Collegiate understanding and respect An element of teaching (which requires some expertise)
52. Knowledge (collective expertise of members) Information (availability of patient related data) Support (co-ordination, administration) Environment (room facilities etc) Time (for attendance and conduct)
53. knowing the patient clinical information rather than flicking through notes
54. input from all support specialties good data collection
55. individuals who really want to work as a team and who are given the resources to do so.
56. Honest discussion using evidence based management wherever possible. Respect for others' opinion. Someone who knows the patients to present the case/take part in discussion. All information (histopathology, imaging etc) available for the discussion. Good chair/lead to channel discussion, moderate opinions. Appropriate surroundings where everyone can see/hear/be heard. Effective method for recording discussion and decisions.
57. Having core personnel present and all data at hand without interruptions and bleeps
58. having all appropriate disciplines represented at senior levels to discuss all available options for patients and to recommend optimal management
59. Harmonious and dedicated team players.
60. Good working relationships between colleagues, good organisation, sufficient time, enthusiasm for the disease-type
61. Good understanding between clinicians. Useful support from radiology and pathology. Opportunity to collect clinical data if support available
62. good team working, ability to discuss cases logically and openly, good MDT coordinator
63. Good team work. Involvement of all main disciplines. Enough time for discussion of difficult decisions. Prioritisation. Lack of repetition. Development of protocols to guide decisions

64. good presentation of clinical issue, good decision making, good data recording
65. Good organisation so all clinical information is available to inform the discussion. This includes an individual who has assessed the patient. representation from all necessary professionals. Not too many different teams from different trusts, this makes the MDT too long and unwieldy and of no interest to a large cohort of the attendees. Good chairmanship Real time documentation for the discussion and decisions. Availability of the discussion and decisions on the hospital EPR ASAP
66. good leadership/chairman, with representation from all relevant specialties
67. good IT. Video conferencing normally functions but functions badly. The radiology is poorly displayed on one site, the technology picks up lots of background noise but not what people are saying clearly and always one MDT is the poor partner. In addition to representatives from all staff must be present all weeks particularly radiology
68. good infrastructure - clerical support, easy transfer of information, adequate MDT co-ordinator time, secretarial support team work good path and imaging support and input
69. good collation of the data to present the cases. Presence of the relevant clinical team members from the different specialities involved in the care of the patients discussed, including specialist nurses and research staff. efficient recording of decisions which are then ALWAYS available when anyone in the team (who may or may not have attended the MDT) next see the patient. Commitment from all specialities to attend with cross-cover arrangements
70. Good chairing (preferably not by a surgeon) to ensure things don't get bogged down; environment where all feel able to participate; good IT so that all information is available; clear lines of communication so that decisions are effectively disseminated; representation (either in person or via IT link) from all hospitals in Network whose patients are being discussed
71. Good chair of meeting with organised support.
72. Good attendance, good chair, receptive team (to each other), everyone together (not videoconferenced!!)
73. Good attendance to facilitate consistent forum for decision discussion. Effective follow up by key worker of decisions made eg OPD referrals
74. good attendance of the core members, timely presentation, not very many patients to be discussed, good documentation and finally good follow up the decision of the meeting for implementation.
75. Good attendance by all core members Respect for everyone's views Open debate
76. Good administrative support, easy access to clinical information, succinct presentation, accurate recording of decision making, good IT.
77. Focused, capturing all relevant patients and clear in outcome documentation
78. Firm chairmanship; participation by as many members as possible, as equals; adequate technology; enough time.
79. Face to face interaction with a range of professionals who work closely together and who have mutual respect for each other's skills and expertise. Good MDT support and accurate documentation are essential.
80. Everyone present. Information readily available (summary, notes). Timely and comprehensive referrals (at least reports of path and radiol, ideally slides and CDs sent with referral).
81. engagement of all stakeholders, effective communication

82. Efficient organisation prior to the meeting. Radiologists/pathologists to have had time to review imaging/slides prior to the meeting. Multidisciplinary input. Individual responsible for chairing the meeting.
83. Efficient focused and well attended
84. Efficient Team work Good communication
85. effective chairing/good preparation/ not too many cases / cases prepared eg by radiology beforehand to speed presentation/ good data collection
86. diplomatic chairperson, plenty of time good facilities and friendly non-confrontational approach to encourage full participation

87. Creating a culture where all members can express a view and latest evidence can be introduced. Challenging approaches should be viewed as healthy and not undermining the process. Those who know the patient should be encouraged to present their case so a full picture of fitness and wishes for treatments can be ascertained. representation should be kept to a minimum and someone should be identified at the MDT to whom the case will be referred.
88. Correct mix of clinicians with adequate Admin & clerical support, good underpinning protocols
89. Core relevant members present, or cover. MDT data collection and electronic referral. Ease of image transfer. Data collection and audit
90. contributions from several disciplines, open discussion of all possibilities, full information available and interpretation where needed, time for consensus to be achieved, opinions of those giving treatment respected
91. concise presentation of case all data available knowledge of patient time for teaching/discussion
92. Concise discussion. All information present at MDT and patient know to a member of MDT.
93. Concentration on the appropriate, complicated patient
94. commitment of members particularly CNS
95. Committed, interested professionals with relevant expertise who commit to attend regularly. Good documentation of question considered, discussion and decision reached and why. Tracking patients through serial MDTs at various decision points in their 'cancer treatment pathway' requires dedicated coordination administrative support.
96. colleagues who share the same vision and are interested in cancer and clinical trials. believe in what they are doing rather than a tick box exercise. geographically located in the same place. good communication
97. colleagues who communicate well - respect the input of the coordinator, use common sense, see the mdt as a generally educational process as well as an important part of the patient's pathway
98. collaborative working between specialties and disciplines, adherence to guidelines, careful informed discussion regarding complex cases, data capture
99. Cohesive group of clinicians. Effective chair, Suitable processes to ensure that MDT decisions are translated into appropriate actions. ie decision that a patient should be seen in a particular clinic should be arranged via MDM and not require clinician to clinician referral
100. Clinician knows pt they are presenting. All participants in same room Good chair person to keep MDT moving and relevant. Clear decisions made
101. Clear presentation of case (including histopath and radiology), plan for patient management devised by all core members collaboratively, summary of decision and reasons noted and put onto a database if available
102. Clear leadership, organisation and a good working relationship with the team members
103. Both of the above. Commitment from clinicians, specialist nurses, radiologists and histopathologists
104. Authority to ensure all patients within area are discussed and managed according to guidelines
105. Appropriate timing (ie not outside normal hours of work), adequate time for discussing all cases, List and brief details of all patients to be discussed, access to c/notes and radiology images, histology reports and all other relevant information at the MDT, presence of all relevant staff, documentation of outcome for each individual patient in the case notes, communicated to other teams (eg palliative care, oncology, gp) where relevant.
106. Answers to 8,9 [*need for MDT coordinator and data collector*] apply to some but not all MDM's. Need full range of specialist clinicians, data collection and time to review information gained audit of adherence to updated guidelines for treatment
107. an effective chairman who understands the role of an MDT is essential. My experience of MDT's in DGH/units is that they have all to often become a mixture of cancer MDT and unit xray meetings. This greatly increases the number of cases for discussion much of which does not need to be formally discussed at a cancer

- MDT. To me this is a huge ineffective use of specialist time. When you think about the annual payroll of staff at an MDT, it is a very large number. My MDT's have 8+ consultants and many more CNS's etc. For unit MDTs to go on for 2hrs or so is a good sign that a lot of inappropriate stuff is filtering through.
108. An effective chair is essential, with good teamwork between all members of the MDT. There must then be clear and concise case presentation with a clear clinical question, the radiologists and pathologists need to present their data concisely and all results must be available. A clear outcome needs to be effectively recorded.
 109. All relevant patient related information, imaging and histology available. At least one person present who has personal knowledge of patient. Mutual respect between participants; effective outcome documentation and clear plan for action to be taken which is clearly documented in notes and therefore available to the professional who next sees the patient.
 110. all members present all the time
 111. All members of the team need to be interested in the subject, including the pathologist and radiologists. Data collection can add to that interest but is seldom available.
 112. all core members present and not excessive number of patients- after 2 hrs one starts to feel detached from reality
 113. adequate time and food not having to worry about targets
 114. ability to consider each patient fully good / full info for each patient open / equitable discussion definite plan for each patient
 115. A well-trained, well-educated, properly supported group of committed people working efficiently to discuss patient cases, and effective dissemination of those decisions
 116. A team working together in order to decide best care options for each patient
 117. A team approach to organisation, meeting, discussions and application of plans
 118. A organised chair, respect for all clinical decisions from members. Time for debate on clinical policies. Presence of palliative care member. rapid results - eg histology.
 119. A local grouping which discusses patients who are known to at least one member. It doesn't take too long. It encourages a level of interest such that physical presence in the meeting is equivalent to intellectual presence. It doesn't itself insert delays into the patient journey; it can ratify decisions taken by clinicians rather than the clinician being obliged to wait until the meeting before taking routine action.
 120. A leader with effective communication skills to guide the meeting and coordinate health professional's opinions on a case is vital. It is also essential that the meeting is organised and well planned in advance.
 121. a functional team, representatives from all disciplines, patient centered, educational
 122. A forum that brings together experts in the field to make informed treatment decisions for patients as well as a focus for teaching, audit and research.
 123. A core team of relevant professionals who have respect for the process and the MDT group, it needs to be well organised and have clear objectives
 124. A chair who knows how to chair! One of the MDTs I attend is not chaired well, not clear what the final plan for a patient might be. cases not all discussed etc. good attendance by core members accurate minutes proper review of all results not just reading for example a radiology report which may be incorrect. adequate time all parties interested and have some knowledge
 125. 1. One that has no hierarchy amongst the members so that everyone is happy to challenge any decision made, without inhibition. 2. Has a good chair who has a clear action point at the end of the discussion. 3. Carries out the recommendation efficiently and has good communication to all parties. 4. Has adequate cover for the core members so that decisions do not need to be delayed during annual leave
 126. 1) Improves quality of patient care 2) Improves communication between professionals 3) Has clear outcomes that are circulated and acted upon 4) Is

time efficient

127. 1 Efficient collection of scans, pathology etc 2 Strong chairmanship 3 Robust annotation of decisions

The team

What qualities make a good MDT chair/leader?

88 oncologists responded to this question.

1. Wisdom and tact
2. Views need to be respected by all members of MDT and commitment
3. unbiased. fair. alert to all members of the team. able to include all members' opinions. respected professionally within the team.
4. Tolerance and an ability to summarise a situation.
5. TO BE FAIR, SUPPORTIVE, ACCESSIBLE TO EVERY MEMBER OF THE TEAM
6. Time awareness, ability to summarise, respect of and for colleagues, clinical knowledge
7. the above
8. The ability to allow time for all cases to have a fair discussion. Being able to quieten the more vociferous and encourage the timid members of the team.
9. Team working, leadership skills. Control meeting - move discussion on when necessary, focus when necessary. Respect for all members.
10. Tact, ability to keep meeting moving
11. someone who is concise and keeps all members in mdt focussed. Does not allow too much discussion on same issues without calling for conclusion.
12. Someone with sufficient authority to hold the meeting to time and order.
13. Someone with a clear view as to how to manage the MDT
14. Someone who is clear and concise, who doesn't talk too much, and who listens to other contributors
15. someone who can makes sure all relevant information and views can be brought to the table, can then allow enough but not excessive discussion, collate and record an agreed decision and then enable the MDT to move on to the next patient!
16. sENSITIVE DECISIVENESS
17. Sensible, polite and able to have respect of all members.
18. Respected, able to control the discussions to focus on the patient, able to ensure all members are included
19. Respected by team members , efficient, precise, good at summarising, inclusive, knowledgeable....will have to steer discussions, able to challenge, endlessly patient, if possible humourous, multi tasker , outside the MDT able to rally a team to the service and the patients cause. Prolotes the service within the organisation
20. respect of team time management good knowledge of conditions being managed
21. Respect of peers. Listening and communication skills. Organisation and ability to keep meeting appropriately focussed.
22. Respect of other members
23. Respect from colleagues and a lack of ego
24. respect for all, ability to involve all, well structured approach, good communication, ability to deal with potential conflict
25. respect and clear communicator
26. quick, concise, respected by other members, good grasp of the subject
27. presence'; clear logical thinking, ability to control a meeting politely but firmly
28. preparation, control, experience
29. Personable. Able to move through a busy agenda, with full discussion but not allowing deviation from the case discussed. This needs to be done in a firm but

- benign manner
30. patience
 31. opportunities to involve appropriate participation esp allied health professionals, timekeeping, organisation
 32. Not letting any one bully members of team who may actually be better informed of the evidence base of the treatment options. To not allow any dysfunctional behaviour.
 33. my experience was the best system was in a hospital where the lead rotated each week - this brought the perspectives of each group to the decisions. the best chair was the chaplain followed by the education specialist!!!!!!!!!!!!
 34. logical thought and good communication skills
 35. Leadership, ability to keep members focused, encourage input from less "vocal" members
 36. Knowledgeable, fair, firm, tactful, decisive
 37. Keeps control to prevent waffle or deviation from issue at hand. Inclusive. Respected by others. Sensible. Knowledgeable.
 38. Integrity, knowledge, ensuring balanced input from team members
 39. I do not think that patient-centred management decisions are at odds with evidence-based decisions. In fact, I would argue that evidence-based decisions are the most patient-centred.
 40. Humour and flexibility
 41. good understanding of clinical scenarios
 42. good time keeping good organisational skills good supportive team (co-ordinator etc)
 43. Good relationship with members. Appropriate assertiveness. Timekeeping. Clarity.
 44. Good listening skills and ability to get people to focus
 45. good leadership and communication skills
 46. Good interpersonal skills. Ability to engage others in discussion, keep discussion focused and summarise conclusions.
 47. Good interpersonal skills enabling communication between participants
 48. good communication skills, awareness of time constraints, ability to ensure participation of all members
 49. Good communication skills, ability to be concise, ability to organise and keep to time.
 50. good communication skills room in their job plan
 51. Good command and control
 52. firmness
 53. Fair Organised Good communicator
 54. Expertise in the tumour type plus avuncular charisma.
 55. Experience, respect, knowledge. All in short supply in some of the teams of my experience.
 56. Even handed & respected
 57. Enthusiasm, clear thoughts and actions, straightforward
 58. Engagement of appropriate team members, time-keeping,
 59. encourages and acknowledges all contributions accepts patient-centred discussion progresses meeting! curtails discussion when necessary
 60. efficient, clear, keeps all to the point, avoids ramble chat anecdote and doesn't allow side-chat - FOCUSED
 61. Efficiency, good-humour, incisiveness, intelligence, expertise - a good working knowledge of all aspects of the disease / issues, so that the discussion can be appropriately focused. They also need to be respected.
 62. Decisive, good time manager, disinterested re specialties
 63. Comprehensive knowledge of the field from the perspective of current research literature. Sadly most MDT leads follow the manager role e.g chest physician in lung cancer MDT and are really lost when treatment is discussed. This is probably historical but also speaks to the low status of medical and radiation oncologists in the UK
 64. Communication skills, Respect.

65. communication
66. clinical involvement and motivation
67. Clear communication Organised Inclusive
68. clarity of thought, a broad understanding, patience and a sense of humour
69. clarity of thought
70. Clarity and brevity
71. Charisma, fostering shared objectives
72. chairmanship of meeting vision approachable communication
73. Articulate, ability to summarise, listen to others views, humour, time-keeping,
74. allowing proper discussion and contribution by any member of mdt. summarising decisions use agreed protocols
75. Allowing all team members to contribute Allowing all team members to feel that their contribution is valued Allowing adequate debate in complex cases But also ensuring that meetings don't drift on Summing up cases if there is any confusion Ensuring that the appropriate team members know what their roles are within the meeting and also following the meeting.
76. all above (Q35)
77. Able to present the relevant facts and liaise between all members expressing an opinion
78. able to move through the agenda in a timely manner; able to give all involved an opportunity for input
79. ability to summarise plan clearly
80. Ability to progress rapidly through uncontentious cases, but to achieve balanced decision in complex cases
81. Ability to move the discussion on when goign off track but at the same time ensure all views are aired
82. Ability to do all the points in Q35 - and respect from the rest of the team. Fundamentally - communication
83. Ability to control the group and prevent long and circular discussions
84. ability to communicated. respected by team,
85. Ability to be concise and focussed, a good time keeper, a good listener, ability to be a good team player - listening to others and respecting their opinions
86. Ability bring all members in, summarise and adjudicate
87. a clinician with common sense
88. a clinician- not a radiologist, calm, but most importantly passionate about cancer

What types of training do MDT leaders require?

71 oncologists responded to this question.

1. Will vary enormously between individuals - some of my Chairpersons just seem to have the qualities, some never will have!
2. Whatever is required to achieve 36 [referring to Q36].
3. used to chairing meetings; good listener
4. training to be a consultant is enough
5. time management/chairing skills
6. Time keeping, communication skills
7. They need to be leaders in their field academically and should have a research degree and be constantly training by taking part in research.
8. They need a knowledge of the subject and an ability to recognise what is important.
9. responsibilities regarding peer review and management
10. Reflective learning (look at a tape of their own MDT) + see how real MDTs are run successfully elsewhere (not simulated MDTs!)
11. practical training (ie role play or supervised practice) in running "normal" and videoconferenced MDTs
12. Please don't make us go on yet more courses.
13. People skills
14. People management skills
15. Organisation/admin skills & leadership/management training
16. not sure specific training would help
17. Not sure it exists
18. Not sure
19. Not more training please. We are now becoming more and more like nurses. Can't do an ECG without a certificate. Can't do urinary catheterisation without having been on a course. As doctors, we now have to do so many courses there will not be any time left for patient care. Can't communicate to patients without having been on an advanced communication course. Can't educate registrars without having been on a course. Can't appraise your juniors without having been on a course. Can't interview without having been on a diversity course. And so it goes on. Where will it stop? Will this survey lead to all MDTs having to attend a course on how to run an effective MDT. There is already the Pelican centre for colorectal cancers. I now see XX [area] are setting up their own Urology MDT course.
20. None specific
21. none specific
22. none
23. none
24. Network organisation and guidelines. Trust organisation and guidelines. Team working, leadership skills.
25. Negotiating skills, conflict resolution, time management, how to chair a meeting, communication skills.
26. Negotiating skills and assertiveness training
27. Maybe a short course plus online learning on how to effectively chair meetings
28. May not be necessary in all cases - some people are natural leaders, but in some cases leaders may need to learn about valuing all contributions equally, ensuring all core members have participated etc.
29. Managing meetings/MDT course.
30. Learning to control a group of alpha males
31. leading groups, chairing meetings, ,managing conflict, delegating, setting standards.
32. leadership training
33. Leadership skills, IT training, communication skills training, and a huge dose of

- good temper!
34. leadership skills training communication skills training on up to date management of their tumour site
 35. Leadership skills
 36. leadership course
 37. it depends on the individual
 38. I think the skills required should be part of generic specialist training not something additional
 39. I suspect it is more a matter of personality traits rather than training. Communication skills training is probably the most useful
 40. I can think of no specific type of training that would help.
 41. how to include all members of the team. how to moderate discussion and prevent acrimony. how to summarise discussion and recommendations.
 42. HOW TO CHAIR A SUCCESSFUL MEETING
 43. how not to let an individual drive their opinion over others
 44. good grounding in evidence for the subject area not just their own discipline. knowledge of clinical trials, leadership, communication skill, time management
 45. Good common sense is required and cannot be easily taught
 46. generic management and leadership skills.
 47. Formal mdt training
 48. Feedback from experienced colleagues
 49. Experience
 50. experience
 51. Either you've got it or you haven't!
 52. Depends on the individual.
 53. Dealing with difficult or awkward colleagues
 54. dealing with colleagues who do not subscribe to the idea of team working
 55. CONFLICT RESOLUTION, ADVANCED COMMUNICATION SKILLS
 56. Conflict resolution!
 57. compassion and common sense specific training makes a "mould" that is then hard to break
 58. Communications skills training
 59. communication, time and man management skills
 60. communication skills course, how to chair a meeting
 61. Communication skills
 62. communication skills
 63. Common sense combined with an understanding of the subject is all that is required
 64. committee management
 65. comm skills
 66. chairmanship and communication skills
 67. chairing meetings additional responsibilities for PEER review
 68. Broad training in their field of work, general training in leadership skills (leaders are not born but are developed systematically)
 69. advanced communication skills
 70. ?
 71. ?

What makes an MDT work well together?

75 oncologists responded to this question.

1. Working together outside the meeting. Good communication. Resolution of differences and difficulties.
2. Willingness to give and take
3. Wide knowledge of the subject, non-entrenched views, respect.
4. tolerance of individual personalities
5. team working mutual respect for all members of team
6. team spirit
7. tea and cake
8. Strong chairing by an inclusive chairperson who also keeps the pace of the meeting reasonable.
9. Sharing common objectives
10. Shared values, mutual respect, patient focus
11. shared passion of cancer
12. Shared objectives, commitment to change
13. Shared objectives
14. Shared goals. Mutual respect. Open-mindedness. Willingness to learn. Desire to make things better.
15. respect.
16. Respect for other team members.
17. Respect for each others views and for the patient
18. Respect for each others ability/knowledge
19. Respect for difference
20. respect between members, good organisation, a bit of humour!
21. Respect and courtesy for all members
22. Respect
23. respect
24. recognition by its members that we are all no more than cogs in a machine that when it works together can materially improve patient care
25. Putting interests of patient first
26. protected time for it
27. professionalism - which means working with people that we wouldn't choose to have as friends -
28. professional respect of all the members
29. professional respect and confidence in each others opinion
30. people willing to be conciliatory, generally if patient focussed (rather than being interested in their own agendas or point scoring) this works
31. peer and organisational support
32. OFTEN INTANGIBLE. COMMON GOALS ARE IMPORTANT
33. mutual respect; similar vision of service and of patient care
34. mutual respect; good understanding of the overall patient pathway and how the pieces fit together
35. Mutual respect. True consensus on opinions formed. A feeling that it is worthwhile! (see q38.6)
36. Mutual respect. Stable team working with limited number of changes to personnel
37. Mutual respect.
38. mutual respect, understanding of the roles / pitfalls colleagues face
39. Mutual respect for each other
40. Mutual respect for all members
41. Mutual respect and good organisation (as previously indicated)
42. mutual respect and confidence in each others capabilities and good team working
43. Mutual respect

44. Mutual respect
45. Mutual respect
46. mutual respect
47. Meeting (in work and socially) out of the MDT Trust Respect
48. Livey debate and some element of fun.
49. its all driven by the chairman
50. if all members feel valued and respected, encouraged to express their opinions
51. High level of knowlege is the most essential factor. The ignorant may rub a long well happily performing at a low level but that is not what the public want. They want a high level of performance and outcomes and if that means arguments so be it
52. Having the same agenda - good patient care and the willingness to all work hard and see the person (the patient) behind the discussion.
53. Good working relations with the core members
54. good team work. appreciation of all members both core and non core. Each member taking responsibility and accountability for tasks assigned them
55. good professional relationships
56. Good physical environment, good mdt preparation, convenient meeting times, refreshments, good leadership, respect for each other.
57. good organisation of meeting, keeping to time, getting on with each other.
58. Good organisation and leadership Achieving the common purpose of effective management planning
59. Good morale and team members working well together
60. good interpersonal and professional relationships focussed on the task in hand ie the patient
61. good communication, respect and understanding of everyone
62. good communication
63. FOCUS and clear responsibilities
64. Expertise - people who all really know what they are doing medically, can express themselves concisely and intelligently and who all want to do the best for the pt with no other agenda. The biggest challenge for MDTs is every individual keeping up to date in their field and sharing that. Personality problems can be overcome, if everyone is professional and expert, but if some people are clueless and confrontational, it's a weekly disaster. We found the national programme of group-educating the colo-rectal MDTs at the Pelican Centre really helped our group, both in terms of education and getting to know people away from the tension of the MDT environment
65. effective leadership lack of personality clashes/egos
66. core team get on
67. Common objectives to improve patient care
68. Being part of teh whole hospital community
69. Adequate time, inter-personal chemistry, absence of rivalry, absence of single overpowering individual
70. acceptance of collective decision making, recognition that all patients need discussion not just theirs/ those within their area of responsibility.
71. A shared goal of good care for patients.
72. a sense of humour and coffee
73. A real team spirit.
74. a healthy respect for everyones opinion and trust in ones colleagues
75. A good knowledge base, a lack of ego and enjoyment of a job done well.

Infrastructure for meetings

What is the key physical barrier to an MDT working effectively?

109 oncologists responded to this question.

1. Waiting for one chairman to write in the notes before moving to the next case
2. Visibility of images, ability to read database. This necessitates the theatre style. Projection should be towards the short side of a rectangular room.
3. viodeconferencing
4. Video linking with staff from other centres that you do not know! (This process is easier if you already have a professional relationship with these colleagues).
5. video conferencing not clear or not working properly
6. video conferencing
7. video-conference. Difficult to discuss cases as easily and involve everyone in discussion. Link keeps failing
8. travel to different hospital
9. too small a venue, no ventilation, no fluids for rehydration
10. Too many cases in insufficient time
11. Time pressures.
12. Time for all to be available Travel by some members of MDT - time taken, teleconferencing not as good particularly for interaction with other core members, and radiology
13. Time and space - I've done MDTs in very cramped rooms, and they're hopeless. I like a great big table - it's good for equality of specialities and professions and promotes discussion. Nothing to stop you eating lunch at the same time - better than hypoglycaemia!
14. time (is that physical?) poor IT with video-conferencing (bad sound/vision)
15. the relationship between chair and participants
16. The key barriers are not physical
17. The images take too long to load
18. teleconferencing- those not at central location feel peripheral and can't see facial expressions and gain the nuances
19. technology to display patient information and images
20. technology problems
21. Technology not working.
22. technology not always working
23. Technical hitches
24. stuffy room, poor seating plan
25. Staff present and PC access!! Both equally import
26. Space.
27. Some professionals not turning up, allied professionals afraid to speak out
28. Some members being out of site (& so out of mind) and effectively ignored.
29. Small cramped non-dedicated rooms
30. room size, room availability poor technology
31. Room layout and therefore sound quality - esp for video conferencing
32. quality of vc equipment
33. quality of IT, Time for members to attend without outside distraction.
34. Professional relationships of key members
35. probs with teleconferencing
36. poor video conferencing facilities
37. poor video conferencing facilities
38. Poor video-linking for multi-site meetings leading to waste of time and miscommunication. Also lack of attendance of core members, encrypted reports etc.

39. Poor venues, away from the main hospital/ area of work. Often cramped with poor acoustics
40. poor technology- having to wait for long periods for images to load/technology to move between modalities
41. poor sound, vision
42. Poor projection of radiology. Lack of face to face encounter between clinicians.
43. Poor preparation by referring clinicians, inadequate information
44. Poor organisation and too many people in the room; often over 20; this makes it difficult for core members to be heard, is unnecessary, bad for patient confidentiality and impairs effective discussion; it is often difficult to follow conversation since too many people involved.
45. Poor lighting, poor display of images (esp when teleconferencing). Lack of oxygen!
46. Poor IT, poor acoustics
47. Poor IT support
48. poor facilities
49. Poor display of radiology. Cramped room with poor acoustics
50. poor communication; poor information provision; poor team play
51. poor chairmanship. Having worked in a range of different MDT's at different hospitals I personally feel oncologists make better chairmen of a cancer MDT. They focus directly on the malignancy/PS/stage/grade etc.
52. Poor acoustics, poor teleconferencing etiquette
53. People talking at once, jumping from one patient to another without concluding one before the other. Notes missing.
54. People talking amongst themselves during discussions such that others can not hear -particularly with video conferencing
55. Not having all the relevant people or investigations available when a case is discussed
56. not enough time, not being able to see each other
57. not being in the same and teleconferencing.
58. Not being able to see your colleagues
59. Not being able to see the screen or other members
60. not being able to see imaging/ path/ other people
61. Not being able to see everybody
62. not being able to hear the discussion or see the images
63. Not being able to hear all the discussion
64. Not being able to be heard/to hear and not being able to be seen/to see and difficulty viewing imaging
65. No equipment such as no microscope or breakdown in PACS system to show radiology. Being told that the designated room has been given to another group such that we need to move into a make-shift room.
66. Members unable to view path/radiology and therefore feel less confident to contribute
67. Location outside the hospital where you work. Those video conference suits are utterly useless and slow everything down.
68. Lack of space and imaging facilities
69. Lack of preparation time. Core members not having time in job plan to attend meeting due to clashing commitments.
70. lack of key patient data - usually performance status, comorbidity, social support and social responsibilities
71. Lack of equipment to display imaging
72. lack of case notes/electronic patient data
73. lack of attendance by radiologists
74. lack of adequate facilities and people involved who are not interested in the cancer management
75. knowing the patient history / data. All too often this is unprepared by diagnostic colleagues
76. IT failure

77. insufficient space and lack of good viewing facilities for all members
78. Incomplete information
79. Inability to review imaging and pathology
80. inability to hear discussion clearly.
81. Inability to hear - chairs in rows means you can see screens, but hard to hear each other. Lights often dimmed, so easy to go to sleep!
82. In ours it is acoustics
83. Heat and lack of oxygen
84. Having to use video conferencing. Makes for a very disjointed meeting. More important to meet face to face.
85. Poor quality voice communication - many teams demand videoconference facilities, with inferior sound, when what is really required is a teleconference with adequate prior distribution of results/images/documentation.
86. Getting core members to be present, since videoconference is not quite so good. Size of room and positioning to image / diagnostics. or microscope for pathologist
87. frustration with the VC / projection equipment
88. failed technology
89. equipment not working properly; rooms do not permit eye contact between all participants; poor software development for data recording
90. equipment malfunction
91. Equipment failure
92. ensuring technology works well. Video conferencing is still a challenge
93. Difficult colleagues
94. conflict between individuals or a surgeon that can't be told or just does his own thing as he is the surgeon
95. camera and tele-link via phone line is poor
96. breakdowns in video linking or image quality
97. Bad videoconferencing facilities. I have lost count of the number of meetings that have been disrupted by dropped connections, inaudibility etc. The technology has been disappointing.
98. BAD IT as all ours rely on videoconferencing
99. availability of core members and clinical information when video conferencing the link needs high quality IT
100. Availability of clinical investigations / IT
101. availability of clinical data
102. AV equipment and video linkage of high quality very important. If this is poor, including poor sound and lighting equipment for video links
103. Acoustics.....
104. acoustics temperature lack of food
105. Acoustics of the room. There's one room with an air conditioning hum and we just can't hear each other....
106. Access to information for all present
107. Ability to view video linked images and quality of video link
108. A room large enough for everyone to be seated comfortably, with adequate air-conditioning (4 computers, a microscope, a large projector and 30 people generate quite a lot of heat) and coffee.
109. a hierarchy of seating

What impact (positive or negative) does teleconferencing/videoconferencing have on an MDT meeting?

115 oncologists responded to this question.

1. you still need face to face meetings every so often to establish human relations
2. Works best when people know each other already
3. when it works is very effective after a short period of adjustment, whne not working very stressful
4. when good, a reasonable substitute for face to face MDT, - when bad disastrous and frustrating ++
5. We occasionally have technical hitches which slow down the meeting. It relies on an etiquette which is helpful to enforce
6. videoconferencing makes the mdt flow less effectively. Can seriously impair meeting if the equipment is faulty eg poor sound / vision
7. Videoconferencing does mean that certian members of the team can attend meeting. However it is not possible to view imaging well down the video conferencing link and I think that discussion is less easy than when in the same room.
8. Videoconferencing can cause breakdown/slowness of image transfer etc which is very frustrating. Need very good chairmanship and good videoconferencing courtesy.
9. Video conferencing requires skills that many do not possess. It is necessary for effective chairs at each end to ensure engagement of all the participants and avoidance of multi-indisciplinary behaviour
10. Video conferencing can work very well but has the potential to marginalise the smaller group. Needs more work from the person in charge to ensure all views are heard. Need more work to look at 21st century solutions to this
11. video-conferencing technology is ok.Room accoustics is poor.and members knowing how to video-conf.It is quite different from across the table!
12. Video-conferencing is useful only when those using facility can see radiology and pathology being projected to the main meeting.
13. video-conferencing has allowed me to be involved in discussions with colleagues 25 miles away and thus not disrupt the working day. disadvantages are very poor resolution of images, variable sound quality.
14. Very difficult to establish a raport between clinicians
15. VC is difficult to chair - transmission delays - but worst of all messing about trying to get connected
16. useless as the technology is not good enough
17. Useful to have available people who wouldn't otherwise be able to join the meeting but often the equipment fails and also the person at the other end does not feel part of the MDT. They may miss some important comments too
18. unreliable, poor image quality particularly for CT/MRI scans. Poor sound quality
19. those at peripheral centres feel remote- being lectured to by host centre. lack of feel of team building.
20. This is critical particularly for extended networks
21. These conferences are slow and hopeless. The money spent is astronomical for no benefit what ever
22. The picture resolution of radiology is often too poor to make sound clinical decisions, which defeats the object of the meeting. Often the whole system doesn't work, there is no IT backup, so we do the conference over the phone on load speaker, hardly ideal!
23. The one occasion I have seen it used it was extremely clumsy and not effective
24. The main disadvantage of video conferencing is the loss of "informal" networking which can lead to a breakdown in communication and and inability to discuss controversial cases in a constructive non confrontational manner.
25. the key thing here is imprving cover. For example when a thoracic surgeon is on AL there will not be a surgeon at the MDT. If the MDT is merged with a nearby

- centre served by another surgeon, you are more likely to get a good decision
26. The effect is so dependent on the team. VC can be enlivening and even liberating, but it can also be a barrier to good communication and raise tension in a dysfunctional team.
 27. Tele/video conferencing allows distantly based members to take part but does not allow good team-building interactions.
 28. Tele-conferencing slows a meeting down. The additional input by a local clinician whom knows a patient can be advantageous. However, there are definitely limitations to the benefits. The meeting occurs where the Chairman is based and those teleconferencing often struggle to contribute
 29. TC or VC is not as good as attendance in person, but is better than non-attendance. In my view it is best for involvement of clinicians from peripheral sites - core members within 10-15 drive should be expected to attend in person
 30. Slows the meeting. Poor communication.
 31. Slows it down, disinvolves those not present at the main site.
 32. Slows it down
 33. Slows down meeting. Second best to actual attendance. Videoconferencing may facilitate attendance/cross cover for core member leave and may make better use of valuable clinician time if significant journeys are required between base and MDT venue.
 34. Slows down communication (have to ensure each individual has finished speaking as any noise interrupts transmission - hard to coordinate. Radiology and pth does not transmit weel - nor does camera of members - hard to interact except by formal sequential statements
 35. slow, difficult communication - requires determination from whole team to make it work
 36. doesn't help. sound transfer is poor. can often hear background noise but not what people are saying clearly. May see radiology clearly in one venue but in the other venue image may be pixolated and not clear in real time
 37. Second best to the person being physically present.
 38. Scan transmission / histology transmission acn be too pixelated and difficult to view. Chair must be organised. Teleconferencing etiquette must be circulated and comments allowed re position of microphone and audibility of members if placed towards the back of the room. members tend to talk over and across other members in different venues. they should be shown a bad teleconference MDT as a teaching aid!
 39. Saves on travel time
 40. saves on consultant time by removing the travel. Need constant technical support. Limited view of projected imaging. physical and therefore mental detachment possible.
 41. revolutionary
 42. requires more skilled leadership as the process does not facilitate interaction
 43. reduces travel time but gets away from the whole concept of an MDT
 44. reduces interaction mainly due to poor quality of sound and vision
 45. Reduces effeciency (difficulty connecting etc). Impairs personal interactions; I beleive there are major benefits to being in same room.
 46. postive for inclusion negative for communication, body language, time delay
 47. Positive: efficient time management for team members (avoid travelling)
Negative: poor sound quality and it is often seen as a remedial tool to make up for poor working relationships, is lees conducive to team-working
 48. Positive: allows remote sites to participate more Negative: it's not the same as being there in person. It's hard to have good enough resolution on scans and path slides for clinical decision making.
 49. Positive: allows participation from people who are unable to be physically present.
negative: you have to be careful about personal interactions over a videolink as there is much scope for misinterpretation of comments/the development or perpetuation of personal antipathy
 50. Positive impact. It allows those within the network but unable to attend to still integrate their cases

51. positive
52. positive
53. Positive - save travelling time. Negative - easy to get out of it, can't easily tell who is speaking (even with videoconferencing), need excellent IT for everyone to see images.
54. poor visualisation of imaging and path over the link up. For some patients need scans sent over afterwards
55. poor quality, difficult to get a rapport with people elsewhere, if other sites not organised, meeting drags, frequently breaking down, needs 2 people to run it!
56. One can't pretend that video-conferencing is as satisfactory as an in-person MDT. It's better than nothing, but the sound is poor and discussion, really pulling the issues apart, challenging others' views, is very hard if not impossible over the links. It's better than nothing, but it's a much more one-sided discussion.
57. Not face to face - loose team building capacity; imaging and pathology projection usually too poor for review; difficult to hear all conversation being had as generally only able to hear key speaker closest to microphone
58. no experience of teleconferencing but difficult to envisage it working well- no viewing of images when necessary; difficulties of chairing such a meeting where multiple members may input into the decision process in multiple ways. Video-conferencing does enable distance/multi-site involvement but again need for all to be engaged, chairing video-conferences is not easy
59. negative: core member is unable to hear or view images resulting in a very poor interaction
60. negative impact - harms discussion, can lead to confusion. members need to know each other so there must be intermittent physical attendance to the centre meeting
61. negative - slow and can find that pts are discussed that you are not going to see - hence no check that MDT views are followed up positive does cut down time in travelling
62. more effective use of time. equipment can be less reliable.
63. Misunderstanding of comments e.g. flippant or throw away can be regarded as rude across a TV link. Talking over each other. Positive impact is that better attendance by thoracic surgeons & attending less meetings
64. limited experience - it certainly needs particularly skilled chairmanship
65. less personal interaction. easy for less assertive members to be ignored
66. Lack of face to face meeting reduces informal discussion about cases that can be very useful. Limits development of relationships.
67. It is a poor and overly complex way of having a meeting
68. it does not always work and from some centres dialling in - often does not work. Very variable quality in systems provided
69. IT complications affect every single meeting. It is just not robust enough. We are currently auditing how much time is wasted on IT issues. When it works it is fabulous. Teleconferencing is great but is not a substitute for being in the same room,. The interactions are not the same and people need training in how to use both sides.
70. It avoids the huge waste of time that travel to meetings that are not consecutive with other clinical activity incurs. It thereby increases the attendance of key members to be more frequent.
71. It avoids a lot of unnecessary travel but needs to be reliable and of high-quality imaging for radiology etc. Also sound quality needs to be good to avoid frustration and annoyance.
72. It allows all members from other cancer centres to participate
73. Involvement of colleagues who could not otherwise participate. Breaks up flow of meeting.
74. Interesting recent experience video versus attendance. The stuttering style of video styl conf in my opinion limited opportunity to a wide ranging discussion and I though ran the risk of a more didactic decision making processalso only those with the confidence to shout up their opinion took part...the quiet contribution may be missed.

75. interaction between members feels disjointed as often quality if sound not good
76. Increased discussion but increased workload. Quality of link not optimal
77. If it works it allows non-core members to attend but ideally core members should be present
78. I have not used this yet
79. i have done it once only and couldn't hear things very well, so no real experience with this but will be doing it regularly. my one experience i did not feel part of meeting
80. I fpoor very detrimental
81. human interaction between members facilitates better decisions
82. Good impact if it's working properly, which it isn't always
83. Face to face increases the value, as often informal discussion before/after the meeting can be very helpful. Image quality of videoconferencing is poor
84. Essential in rural areas (like XX [area]) but only as good as the least effective bit of kit.
85. ensures greater attendance
86. Enables greater participation
87. enables attendance need politeness and discipline for it to work
88. Dreadful invention. MDTs would be hugely more effective if met face to face.
89. Don't use it in mDTs I attend but about to have to introduce it for regional TYA MDT to be established
90. does make discussion/debate difficult, but still better than not having it
91. do not feel always very effective.
92. discussion is never as fluent or extensive as it is face to face. Imaging etc is not as clear
93. Difficult to establish rapport with colleagues via telelink
94. difficult hearing people and seeing imaging (path impossible) from video-linked sites. stilted conversations
95. difficult discussion to involve everyone. . poor connectivity therefore repetition of cases.
96. differs with each MDT I attend video links in the past have been a disaster, however my experience of the linked netowrk at XX [area] showed that with INVESTMENT it could work - but the technology required isn't cheap!!
97. Delay and poor quality of link impact negatively. However this outweighed by allowing more members to attend.
98. Could not be done without videoconferencing
99. can take more time per patient
100. Can be useful sometimes for those members who are very far away. But imaging is somewhat limited and poor quality ie showing them the CT scan and histopathology often does not work well
101. can be disruptive due to technical glitches
102. big negative if inadequate IT need set manner in presenting greatly facilitated if members occasionally attend central MDT
103. As before, video-conferencing is a pain in the neck. It is a necessary evil, as there isn't time to travel to all the meetings.
104. Although we have it installed in last few weeks we don't use it yet as all clinicians prefer to be present at the meeting even if it involves travel as we prefer to meet face to face
105. Allows wider participation and reduces need to travel to MDTs. Needs practice and strong leadership to use effectively as well as good equipment and technical support.
106. allows specialist s from other cancer centres to join discussion for relevant cases (eg specialist surgeons)
107. Allows more peolpe to partake
108. Allows more members of the team to join on a regular basis, allows occasional attendance by our core team members at other specialist MDTs outside our age group that we sometimes need to attend Image quality is not good enough for histology images

109. allows members to attend and get on with work thereafter Does limit the interaction, not really possible to be fully involved if at a remote location More environmentally friendly Means that workers do not have to find a parking space in the hospital in the middle of the day
110. allows interaction with peripheral hospitals
111. Allows everyone from the network to attend but means the meeting is too long to maintain concentration. As a result people talk amongst themselves and disrupt the meeting.
112. Adds time but is probably worth it unless there is sufficient local expertise for a second local MDM which will be competent and save a lot of time
113. 1 allows access which would otherwise be impossible 2 improves time/travel efficiency
114. +ve - encourages inclusion -ve - enormous problems with IT, not very personal, encourages a them and us feel, quality of imaging/path on screen poor.
115. +: allows key members to attend -: more than 1 V/c attendance prohibits discussion. Technology is not that good yet

What additional technology do you think could enhance MDT effectiveness?

70 oncologists responded to this question.

1. We are fortunately well equipped
2. voice activated recording of decisions
3. trusts to be committed to data collection and development of applications for this purpose (eg InfiFlex)
4. the pacs SYSTEM IS HOPELESS - WE ALMOST NEVER GET TO SEE SCANS FROM OUTSIDE HOSPITALS.
5. The ability to preload all relevant data (images, lab results, etc.) for projection.
6. Systems that are less error prone. Sharing of DICOM images between trusts made more straight forward (ie easy to do without need for discs)
7. Star Trek style transporters (beam me to the DGH and back Scotty) to save us from video-conferencing and endless driving??
8. Skype technology
9. reliable access to PACS in all NHS trusts involved in the network
10. Recording direct onto CRS Cerner system
11. realtime typing in of MDT summary by competent individual
12. Real time recording of MDT decisions is possible but slows down meeting ++.
13. Real time recording of decisions to the hospital EPR, projected onto the screen
14. Real time database input
15. Rapid and better recording of data to provide outcome data easily, I find the databases impossible, a one touch system gathering info from all sources would help here
16. point to point transfer for PACS between trusts IT to prospectively collect data
17. PACS when it goes down is a real problem
18. PACs that doesn't crash all the time; access to PET images which are reported else where; increase ability to load patient images in a timely way onto PACs. This is always delayed for patient confidentiality reasons, so we end up discussing the patient without the images or have to delay the patients discussion for several weeks.
19. PACS and Electronic patient record access to all hospitals in the Network. Electronic access is not possible to all peripheral hospitals and sending CDs with images in the post often delays decision making and it is dangerous. Systems should also be in place to ensure adequate and timely transfer of pathology.
20. Need to have mdt coordinators IT supports sufficiently trained to deal with any

- technology issues immediately
21. Nationwide site-specific databases/proformas for uniform data collection
 22. Much higher quality of teleimaging
 23. Much better quality in videoconferencing. Also ability to get multiple users
 24. More reliable, better quality video-conferencing kit.
 25. More attention needs to be paid to training people how to use/ behave and lighting and sound arrangements
 26. Live data collection Presentation to team of decisions made Automated letter with MDT outcome
 27. larger and clearer images ability to have multicentre interaction
 28. Just better versions of what we already have
 29. Integrating data/decision entry for MDT with data collection in real time in a way that can be easily reviewed "live" by the entire MDT
 30. Increased band speed/width We would love to have a supported on line data base if it worked, was easy to use and didn't break down. But it would need someone there dedicated to operate the system who knew how to do it and could input the info
 31. increase in bits/sec data transfer, images often poor quality esp path
 32. if using TC or VC, previous transfer of high quality images to peripheral sites to avoid loss of definition and/or time with live image transfer
 33. High speed links laptops for decisions to be recorded and projected in real time an effective electronic patient record
 34. high speed access to PACS/notes realtime documentation of decision
 35. High quality radiology displays
 36. Having IT manager at the meeting ready to sort out any glitches in real time.
 37. good radiology, dual screen, screen display patient info and the decision recommendations
 38. Global PACS access for NHS
 39. Fast links with good pictures and sound. Possibility of some members to participate or observe using PC with webcam
 40. fast internet access to web-based databases. electronic patient records with ability to annotate mdt decisions.
 41. electronic database to record core data and decisions and therefore allow output of outcome data in future
 42. electronic database information collection with drop down menus so that information can be gathered quickly and automatically databased PACS connections between hospitals to allow all imaging to be accessed transmission of images between videoconferencing rooms
 43. Electronic board to record decisions real time
 44. effective videoconferencing
 45. Effective IT support for real time recording and appropriate electronic communications to send information out to GP etc
 46. data collection and audit
 47. Cross-site videoconferencing - e.g. group in MDT room in 1 hospital, 2nd group in another hospital - would be better than conferencing in individual offices.
 48. Computer access to photos would be helpful in some of my MDT meetings.
 49. coffee machine
 50. Clinical photographs for some MDT e.g. skin
 51. Clear speakers
 52. better web based video
 53. Better videoconferencing - it feels we are well behind what could be achieved with communications in 2009
 54. better video-conferencing facilities
 55. better video-conferencing - eg ability to consistently view images simultaneously in all sites
 56. better sound with video-conferencing
 57. better resolution for images - allowing bigger screen (on the way in this network - but slow roll out)

58. Better quality picture, and sound
59. better projection facilities
60. Better microphones.
61. better microphones and projection, ideally would prefer to be physically present for the MDT
62. Better IT - more powerful computers, better videoconferencing
63. archived pathology samples. Access to electronic medical records.
64. Access to evidence based medicien resource
65. access to clinic lettes on network in case notes not available
66. Ability to access PACS at other trusts directly
67. a separate telephone line in the MDT room if video-conferencing fails
68. A piece of paer and pencil. A prepared mind would be nice but most folk are so distracted trying to press buttons they can't think their way out of a paper bag
69. A dedicated IT support to have equipment running and ready to start at MDT start time
70. ?

Meeting organisation and logistics

What preparation needs to take place in advance for the MDT meeting to run effectively?

121 oncologists responded to this question.

1. Xray availability, if pt from other team then needs to be at mdt
2. we hope the electronic networks for scans and path results would stop this work but the technology is so slow and unreliable to make paper collectino an absolute reqirement
3. TRial eligibility current problems of patients for discussion (progressing or ?progressing)
4. thorough knowledge of patients I am presenting
5. There needs to be a list summarising the patient history available, preferably before meeting. The list should indicate what aspects are being reviewed (e.g. histology or imaging or both), and the mdt co-ordinator should have ensured that the relelvant parties are aware that they are being asked to present their reivew. The core members such as radiologist or pathologist should have had an opportunity to look at case before meeting ideally.
6. The referring clinician needs to have the relevant facts and reports available and understood. The radiologist needs to review the films (where indicated), the pathologist needs to review the slides (where indicated).
7. The radiologist needs to review the scans, the pathologist needs to know the case and what to present. The clinicians need to be able to present the case clearly, but in my experience I, and most of my colleagues, can certainly do this without dedicated preparation time as long as the case notes are available. The single most important thing is that the clinician treating the patient is there to present and discuss the case. The admin to ensure scans etc are avaiable is vital. I would be very opposed to circulating clinical summaries pre-meeting - I am not at all certain that that is the best use of time or resources, at least for core members. I guess it coud allow extended members to see whether or not they need to come. I would rather see that admin effort used in better minute-keeping and distribution, data-keeping and audit.
8. The list of patients need to be prepared and circulated and the some specialities need to prepare material - mostly radiology and pathology

9. The Lead Clinician and the presenting clinicians for each patient need to prepare by being aware of the circumstances. Orphan patients, i.e. those under the care of clinicians not usually involved in that MDT, need to have an individual to present them who is aware of the patient. I see this as part of the Acute oncology role.
10. the key worker need to complete the proforma for each patient this may be up to 15 cases
11. The clinicians presenting the case need to know the patient. It is essential to have access to the relevant investigations. For those who treat, rather than diagnose cancer, there is little work to do before the MDT meeting.
12. Summarising the clinical case
13. Sort out a pithy summary for each case you are involved in. There's nothing worse than listening to some hopeless shaggy dog story about a patient, then after 5 minutes the junior says 'they died last night'.
14. someone who knows the patient being able to present the case and answer questions re PS if required. All histology if biopsy's taken
15. Scans/ notes and histology need to be available. The patient should have been seen by someone who knows their PMH and preferences, and will present the patient. On a number of occasions the MDT has decided that a patient's tumour is 'operable' but when a doctor sees the patient it is clear they have significant comorbidity which makes surgery high risk and they then have to be rediscussed at the MDT to consider other options which is a waste of time for both the patient and the MDT
16. sadly I usually have no time to prepare for meetings, even the 1 I chair. notes found, summary prepared by clinically able staff, radiology/Xrays reviewed. Ideally the pt should be known to a core member present- this is often not possible, in part due to time constraints, so pts are discussed "in abstract"
17. reviewing patient notes to summarise case for presentation
18. Review/clarify rare histology; contact other clinicians where their opinion is needed; review of previous history/results that may not be represented in the MDT summaries.
19. Review of radiology and pathology, review of clinical history, commencement of data collection, getting notes/other results available
20. Review of pathology and radiology and case note summary for accuracy and up to date.
21. Review of imaging prior and pathology by radiologist and pathologist. A member of the MDT familiar with the patient should be present to present the history
22. Review of imaging by radiologists, review of pathology by pathologists, knowledge of history etc by the person presenting the patient
23. Review of case notes, preparation for questions to other team members and additional information about rare cases, review of treatment options
24. Review of case history, histopathology and radiology
25. review imaging review path presenter to know case
26. retrieving case notes make sure investigations have been performed and results available conclusions from previous meetings should be available clinician who knows patient should be present
27. request of imaging, pathology etc from referring hospitals notes availability radiology and path review by respective presenter
28. read through clinic letters this is disproportionate as radiologists and pathologists need to spend over 90minutes but clinicians need only to familiarise themselves with patients they already know
29. Radiology reviewed by expert. Clinical information obtained. Histology reported in time.
30. radiology review, knowledge of patient you are presenting. knowing what questions are to be answered
31. radiology and pathology review. Occasionally we present cases as oncologists and need to work up but not a great burden on us as oncologists
32. Radiology and pathology review
33. radiology and pathology review. clinical case summary
34. Radiology - review all relevant imaging to question being addressed Pathology -

- review all relevant pathology question being addressed Clinicians - ensure adequate history and appropriate question being posed provided so clear presentation then given oncologist - opportunity to review information prior to meeting e.g complex cases/ trial suitability
35. Radiologists & Pathologist reviewing their cases
 36. radiologist, pathologists need to do lots of preparation. As a medical oncologist I prepare patients I am taking but as I don't get any info about patients to be discussed am unable to do any more preparation
 37. Radiologist review scans, and pathologist slides Oncologist review treatment options if a difficult case is to be discussed
 38. provision of history if clinician not present
 39. previous patient pathway needs to be made explicit
 40. presenting clinician should have thorough knowledge of case and appropriate investigations. All imaging and path should be available for review.
 41. Preparation of Patient list with brief summary, collation of all information, request for case notes/images/histology. Professional presenting the case needs to ensure they are familiar with details of the case to be presented.
 42. prep is needed by pathologists and radiologists. I need time after the MDM to organise treatment for patients either before or after consultations
 43. PMH, treatment history,
 44. Plan patient list ahead (preempt when patients have response assessment scans) and make it clear what questions are being asked and what imaging/pathology needs to be looked at. A doctor who knows the case history needs to attend to present the case
 45. Pathology, radiology, clinical summary, notes, IT, teleconf facilities, diaries
 46. Pathology and imaging - where appropriate - must be reviewed. For rare / non - standard clinical situations need pre-review of treatment evidence
 47. Outside scans need to be put on system. the radiologist needs to look at the scans in advance etc
 48. One person must collect all relevant information and summarise it together with question posed.
 49. Notes, imaging and histology must be available
 50. need to review annotations and summarise history.
 51. Need good referral letter or coordinator needs to extract information from notes. Coordinator needs to chase histology and scans
 52. mostly this is by the surgeons and physicians that refer us the oncologist pts, we do the prep if we have put pt on the list
 53. mdm coordinator to assemble info
 54. making patient history, examination, investigations available for meeting. Considering which clinical trials may be open and appropriate
 55. make sure investigation results are in place, tumour markers, Centre MDT update, members from other teams are aware to come and present the ir patients
 56. Make sure I am familiar with the the cases I have asked to be discussed, including the clinical question to be answered.
 57. Mainly the Co-ordinator gathering all the information, scans, pathology
 58. Mainly done by MDT co-ordinators, I need to summarise histories ensure correct details of history for presentation, getting results
 59. literature review for unusual cases
 60. listing patients for the meeting
 61. List of names and problems so some things can be ironed out in advance.
 62. list compilation, summary preparation (with relevant history / clinical information) + preparation of cases by radiology and pathology
 63. kit set up and working - radiology seen in advance - clinician knowing patients case -
 64. Key things are preparation from radiology (specialist review of imaging), pathology (review of biopsy material) and the principle clinician responsible for the patients care, so that accurate clinical information is available. An accurate case history summary needs to be available
 65. its the pathologists/radiologists and presenting physicians who need time to

- prepare
66. It depends on which core member you are. The radiologists and pathologists need adequate time to review the results. As an oncologist I don't need to prepare before but often need time to act on the recommendations afterwards
 67. Information regarding presentation and previous therapy, radiology, histopathology, coordinator
 68. Information on patients, images, histology, data gathering, attendance register
 69. Individual members need to review the information relevant to them. eg clinical oncologists could review scans and so that he or she could comment on the suitability of radical/ palliative treatments. It also helps to look for references/evidence in case of a rare pathology.
 70. Imaging and pathology needs to be reviewed so that only relevant parts are presented. Notes should be found and a MDT template filled prior to the meeting so outcomes can be recorded during the meeting
 71. If the patient belongs to yourself, a case summary should be prepared and the relevant questions anticipated so that the discussion at the MDT is focused.
 72. ideally the patients you are presenting you want to have gone through prior to meeting ,time however is a major problem. If we wish to have time to prepare all cases then it is not an mdt but a grand round.
 73. I read through case notes of my patients that are to be presented other presenting clinicians need to do the same Radiologists and pathologists need to provide written reports stating any differences from available reports CNS and coordinators need to ensure all info - scans, path, clinical summary is available
 74. I ensure that I have the most up to date clinical annotation and that I am familiar with the questions being posed
 75. good summary of patient information
 76. going through the notes, make sure all the relative tests available and knowing the WHO states
 77. going through notes known to oncology, even if it were for an unrelated cancer. most of the prep work needs to be done by the coordinators and the people presenting the cases.
 78. full case history, imaging, pathology (if appropriate) available with relevant question to be answered
 79. for radiology / pathology they are likely to need 0.5PA per each mdt they attend. for oncologists, physicians - less than that but prep time reliant heavily on the efficiency of the mdt coordinator
 80. For a clinical oncologist, there is usually very little preparation apart from familiarisation with the cases but a few cases (rare or more controversial management decisions) require literature searches/review of guidelines/evidence base before the discussion.
 81. ensuring relevant patient information is available. ie how fit they are, what does the patient want etc
 82. ensuring a clinician who knows the patient will be present at the mdt
 83. ensure the relevant details are readily available to avoid wasting time during the meeting trying to find this out. need to ensure notes are present and someone is available who has seen the patient and is aware of their fitness and also potential feelings regarding the treatment options.
 84. ensure full information available including xrays, scans, + assessment of patient performance status and wishes
 85. ensure correct patients and investigations collated
 86. Ensure all info required to make a decision is available. If not available best to defer rather than discuss twice or three times in MDTs with different members present. Difficult to do in practice as seen delaying treatment and breaching targets
 87. Each team member needs to review their potential / past involvement with patient.
 88. Each member needs to organise and collect data for their component of the case discussion
 89. depends on the role of person
 90. depends on the individual. for a clinician familiarisation with the case. for a radiologist review of the X rays. For a histopathologist possible histological review

91. Coordinator - ensure notes, slides, radiology available - if slides and radiology not there, at least get reports. Pathologist, radiologist - review slides and images. Other members - check list, prepare to present own referrals, be clear on the question for the MDT.
92. Consultants should have up to date knowledge of their cases being discussed; all new referrals should have adequate clinical information for appropriate decision making; all relevant scans etc to be available; the co-ordinating doctor (a sub-specialty Fellow in the case of Gynae MDTs) needs to have a brief summary of all patients being presented.
93. completion of MDT proformas
94. Collection of relevant data and circulation
95. Collection of notes, population of MDT proforma with key data by facilitator for use at the meeting, radiologist review of images BEFORE the meeting.
96. Collection of notes and if specific patients are added by a clinician, there must be a person to present the individual case
97. collation of all the relevant information including imaging, pathology etc. It may well be that radiologists and pathologists need to prepare - but it does depend on the disease, case etc.
98. collate data ensure that clinicians upto date so can give opinion correctly
99. Clinicians to review notes, produce case summary, radiology and pathology to prepare films / slides
100. clinicians presenting majority of pts need to know the pt, know why they are being discussed, and know the question that is being asked. All radiology and pathology should be readily available.
101. Clinician presenting case/s needs to prepare in advance. See above for other requirements: essential to have all relevant available information on each case
102. clinicians frequently know the case anyway, or have notes to hand. A summary on an MDT request form is important Radiologists and pathologists must have preparation time, particularly if they are effectively giving a second opinion on a previously reported case.
103. clinical summary, time for radiologists and histopathologists to review and prepare results of relevant investigations
104. Clinical information to be to hand and available (ie electronic referral proformas). radiologist and pathologist time
105. Clear understanding of case and case should be presented by clinician who has met with patient
106. chair needs to have control over what goes on list; radiologist and pathologist must always have adequate time for preparation; others not so important
107. Cases histories of pts to be presented must be summarised and so therefore by implication, notes must be available prior to MDT. All radiology needs to be available and reviewed All pathology needs to be available and reviewed Lists of pts to be discussed need to be circulated in advance with short description of the reason they are going to be discussed.
108. Case summary for each patient. Knowledge of timing and outcome of investigations. Any relevant CWT targets. Assessment of patient, particularly fitness/PS, symptoms, patient's wishes.
109. Case summary review of what information/tests results are needed stratification of patients eg pre-/post-op
110. Case summaries need to be critically reviewed to determine what investigations and treatment options are appropriate. It is difficult to do this quickly within the MDT meeting when patients have been previously treated or have complex co-morbidities.
111. case summaries esp if relevant clinician may not be there, radiology review on PACS or histology slides and scans on disc need bringing into meeting and preferably seen first.
112. Awareness of the patients to be discussed and the relevant clinical details
113. assessing patient overall and assessing patient's feelings generally about treatment. going through history and blood results.
114. as above - list of patients collated with notes , xray histol available for review
115. All notes, histology and images need to be obtained. Order of cases should be

decided to maximise involvement of those present.

116. all info relevant to the case needs to be available
117. all imaging uploaded from CD to imaging server Case summary prepared results of tests collated
118. all above
119. Administrative: making sure the relevant clinical materials are available - usually radiology and histopathology. It is important that Pathologists and Radiologists have adequate time to review their materials before coming to the meeting
120. A clinician who knows the patient and case to present patient, Time for radiologist to have reviewed images rather than presenting 'on the fly' Pathologist to have considered histology. For Oncology, if the above has been done, then selection of patients for consideration of non-surgical treatments is likely to be more appropriate.
121. 1) Review of case to be presented by presenter and formulation of clear questions to be answered at the MDT. 2) Review of radiology and histopathology 3) Collation of relevant information

What makes an MDT meeting run effectively?

105 oncologists responded to this question.

1. Well prepared proformas, full attendance, adequate time.
2. Well chaired to keep discussion focussed on cases at hand. Avoid side-tracking into irrelevant topics.
3. Usually only discuss 5 cases
4. timeliness with rapid dealing with standard cases and a sense of fun.
5. The skills of the Chairperson, the atmosphere of teamwork and well-structure pathways.
6. the number of cases that can be discussed depends on their complexity. The running of the MDT depends mainly on preparation and chairmanship, but also on members contributing briefly and relevantly
7. The number of cases is dependent upon the tumour type and complexity so there can be no fixed limit
8. The number of cases discussed depends on the tumour type and complexity of cases being discussed.
9. The number of cases discussed depends on the complexity of the cases. MDTs should not run for more than 2 hours as it is hard to keep the level of concentration required to make effective decisions for the whole of that time.
10. Succinct presentations and focused discussion
11. Strong, clear chairing and good preparation
12. Strong leadership to prevent unnecessary waffle and argument.
13. Strong leadership
14. strong chairmanship constructive discussion
15. Someone who has met the patient should be present at the MDT
16. The needs of a gynae meeting are different from those of a lung meeting and very different from those of a breast meeting!
17. Quick decision making in routine cases Defusing arguments quickly
18. Strong leadership, a fairly formal structure, clinical info to hand and presented quickly so the discussion can take up most of the time
19. punctuality decorum well presented cases - symptoms i.e. dysphagia score, performance score, comorbs, what patient knows, demographics availability of all investigations in good time to allow adequate preparation expertise of members access to notes, clinical trial protocols - in XX [area] all electronic
20. preparation, leadership, good team working
21. preparation, good leadership and relations between members
22. preparation of presenters

23. preparation before the meeting. Having up to date notes available. All members being present. Good team working and relationships.
24. preparation and effective chair
25. preparation keeping to the topic in hand if video conferencing used that this works! radiology and path can be displayed well (technology again)
26. preparation - all images / path available / good inter-colleague relations
27. person presenting knows the patient i.e has assessed them clinically- should be medically qualified
28. people turning up on time! Prior prep by coordinator
29. people being present on time and all the relevant details for discussion being available
30. organisation, refreshments
31. organisation of cases to allow time for clinically difficult cases, teaching and discussion of controversial management issues
32. Organisation in advance, good chairman, good team who value and respect each others contribution
33. organisation beforehand; clear leadership and focus during- there is a tendency for individuals to have an agenda eg pathologists who view the MDT as an old style histopathology meeting; radiologists who insist on showing every view of every image for each patient, even when these are no longer needed for this decision point (eg pre-op mammos for post op breast cancer patients requiring adjuvant treatment decisions)
34. organisation and team working
35. Organisation and good chair
36. optimum number of cases is not the same as how many are discussed inside working hours, no lunch etc a counsel! sof perfection. If this all happened there would be significant issues about enough time to see and treat sufcinet patients to maintain expertis. What shodl be discussed needs to becom more strinectn over time- otherwise will eb overwhelming and is already leading to decision by committee with an adevers effect on decisions by resposible clinician and delay in treatment
37. numbers depend on complexity m- breast is easy, H&N v difficult, brain intermediate
38. number of cases per meeting depends on tumour type.
39. No of cases depends on complexity. After 3.5 hours of brain tumours, everybody is flagging, but that's how long it takes to discuss 30+ cases. MDT runs effectively when the key people are present ie those who know the case, when the scans and path have been reviewed, when the agenda is as stated, when everyone is in a good mood!
40. No gossiping, respect fo reach memeber present preparation
41. my MDTs run for up to 2.5 hours which is too long and discuss too many cases
42. leadership, preparation of cases
43. Leadership . Stimulation of interest (engaging all members in the discussions). Having all the materials there to make decisions
44. knowledge of the patients good radiology reviews and preparation
45. its all about having the right info at the right place at the right time.
46. If the referring doctor is there and has the information, if the x-rays are preloaded and the radiologist has reviewed the films
47. Having the relevant people there when a case is discussed
48. having the necessary info
49. having all the data available with clear case summaries, a good co-ordinator, ring-fenced time with core members present, and some chairing.
50. Good working relations between clinicians, backed up by admin and service support.
51. good teamwork
52. Good preparation. Timekeeping. Respect for others. Good chair.
53. good preparation, everything needed available and ability to present cases acurately and succinctly. members present throughout and not arriving and

- wanting then to rego over their patients they've missed
54. Good preparation, availability of all necessary core members, focussed discussion
 55. good preparation
 56. Good pre-meeting organization, running to time and a willingness to co-operate between MDT members
 57. Good planning, a chair who ensures the meeting runs to time, designated person to write up the decisions with prompt circulation of decisions
 58. Good organisation and preparation
 59. good organisation and leadership - oft best coordinated by specialist nurse
 60. good organisation and chair
 61. good leadership; time for radiologists and pathologists to prepare; adequate time for full discussion; easy recall of previous discussions
 62. good leadership, not many patients to be discussed, all data are available and most important the presenting doctor should either being in charge of the patient or has seen the patient for the sake of the MDT
 63. Good leadership from the chair. All relevant information available on the day. Ageed protocols.
 64. good leadership and organisation follow up of decisions made
 65. good leadership and cooperation from the team
 66. good leadership and attendance from all core members
 67. good leadership
 68. Good environment, reliable IT. Ability to hear everyone. Availability of information.
 69. good data strong leadership empowered team -all members able/ willing to contribute. good documentation
 70. good communication, effective leadership, engagement of all members
 71. Good chairing, prompt availability of all necessary information, appropriate recording of management plan
 72. Good chairing of the meeting. When the clinician presenting the case knows the relevant information.
 73. Good chairing of the meeting
 74. good chairing good preparation by radiology/path people being succinct and to the point
 75. good chairing
 76. Good chair, keeps to agenda, keeps cases going. Doesn't allow straying off the list.
 77. good chair, focussed attention on all cases....diminishes with increasing numbers of cases and size of meeting....attendance of all key members throughout....(time wasted if have to repeat cases,) efficient system for ensuring relevant information/date available
 78. good chair, all data required for decision making to be present, avoid unnecessary data eg if path results presented the week before they do not need to be re-presented
 79. good chair
 80. full data availability presence of all specialist treatment modality teams
 81. Excellent chairing and preparation for the meeting (in terms of data collation)
 82. essential to have good documentation of outcome
 83. efficient chair. focus of meeting. ability for MDT co-ord to be able to type!
 84. Efficiency and organisation ahead of time and strong leadership during the meeting
 85. effective time management
 86. Effective chairing, succinct presentations and clearly documented outcomes
 87. effective chairing, practised and prepared pathology and radiology, presence of key personnel involved with patient (clinician and key worker), presence of clinicians needed to make therapeutic decisions (eg oncologists, surgeons)
 88. Clear and concise presentations, and histologists getting quickly to the point and getting off the fence

89. Chair keeping discussion to time. faultless technological support. Projection in focus. Mobile phone etiquette evident.
90. Careful preparation, good attendance, clear leadership.
91. Availability of hot and cold drinks on arrival, and breakfast or lunch if these meetings are held prior to the working day, or during lunch time. Good leadership by informal or designated leader. Focus on cases, not distracted by less relevant conversations. Access to necessary information. Availability of patient list and summary. Adequate space - sounds trivial, but standing for the duration of a mdt, or being squeezed into the back of a room unable to see images properly for over an hour is not maximally productive!
92. availability of information listed previously and availability of previous MDT conclusions attendance and punctuality of core members
93. As above. Key to dislocate specialist MDTs from local non-specialist meetings - to optimise efficiency of MDT members
94. As above
95. Appropriate case presentation
96. An effective chair
97. An effective chair
98. Already answered this! Organisation and mutual respect.
99. all data available limit the chat about procedure
100. adequately prepared cases effective chair efficient MDT coordinator
101. Adequate time and preparation
102. a standard presentation process eg hx, radiology, path etc
103. A good co-ordinator and a good chair.
104. A good chair and good organisation so that there is no duplication of discussion. Case presentation by a member of the team involved in patient's care. Prior review of the case by radiologist or pathologist so that they can highlight the relevant aspects in a concise manner.
105. a good chair preparation good facilities adequate IT (not ISDN lines!) if video conferenced sensible number of cases for time available relevant members present someone knowing the pt

Clinical decision-making

What model of decision-making could be used for patients with recurrence/advanced disease if these patients are not discussed at MDT?

103 oncologists responded to this question.

1. We have an Oncology Unit meeting which happens weekly. This is in essence a non-specialist MDT made up of a Radiologist and all Oncologists. This allows a broad spectrum of opinion and expertise but is appropriate in the Palliative Care setting. We now also use this as a reference group for discussing 'difficult' chemotherapy treatment decisions in light of the NCEPOD enquiry
2. We have a system of 'talk round' after the clinic with at least 2 consultants sharing their decisions about relapses. If they disagree they are then taken to the MDM. Likewise if the CNS disagrees they can bring them to the MDM.
3. Very difficult. Non-oncologists often have limited experience of managing advanced disease (& no expertise in chemotherapy etc.). It may be most useful for such patients to be discussed by the oncologists and the specialist nurses with input from palliative if appropriate.
4. Update at the next available MDT
5. Treatment should be protocolised. Possible discussion with other oncologists, pall care. Inappropriate for MDT discussion if only 1 or 2 oncologist attends.
6. Treatment for relapse or metastasis should be according to MDT agreed protocols for the majority of patients. To re-present every relapsed patient would be a huge workload and take a lot of time.
7. This will vary between disease types. For example it would be a waste of time to discuss a melanoma recurrence in an MDM, whereas recurrent breast disease should probably always be discussed
8. This is much more about tailored treatment to individuals which unless patient comes to MDT is difficult. MDT should express view as to what is reasonable to contemplate.
9. These should be discussed within fora where a number of oncologists treating patients with the same tumour type review patients with recurrent/advanced disease
10. These patients are realistically of little interest to the surgeons, Why not leave it to the knowledge and experience of the oncologist. We are only too keen to ask for help if needed and will put cases on at our discretion. The idea of discussing every patient every time they progress is absurd. I believe NCEPOD advises discussion only of those with poor WHO PS prior to further chemotherapy. PS I do not do Private practice but I am prepared to allow discussion as the numbers are small and I feel it is supportive to our surgical colleagues, However if I was working in an area of the country where private practice was more prevalent I might feel differently and consider it a waste of my time.
11. These are usually protocol driven especially if treatment option is for chemotherapy in the palliative setting only and no evidence of benefit from 2nd line surgical intervention
12. These are usually individual clinician/patient decision. It is quite impossible to bring all recurrences back for discussion particularly when it is clear that no further treatment is possible. However some should be brought back.
13. There simply isn't the time to review every relapsed/ progressing patient in the MDTs. Certain cases benefit from discussion eg late relapses if further management may need to involve other treatment modalities. Consultant assessment and decision
14. There should be agreed pathways (both standard care and clinical trials) for patients who present with relapsed/progressive disease. e.g. surgical teams will not be interested on the second-line chemotherapy management of a patient who has progressed after first-line chemo.

15. there is never going to be enough time to discuss all pts with recurrence so it has to be taken that the oncologists know what to do - they are trained!
16. then there needs to be alternative ways of obtaining multi-clinician and multi-disciplinary decision making. SOle clinician decisions, especially about treatment of the first episode of recurrent/metastatic disease is in my view unacceptable.
17. The responsible consultant makes a decision in partnership with the patient during a consultation
18. The person who knows the patient is best placed to make decisions about fitness for further treatments. MDT can be useful forum for rediscussion but should not be compulsory.
19. The oncologist should make decisions about patients with recurrence/advanced disease. You can only do this sensibly in discussion with the patient, and that can't be done at the MDT meeting.
20. the old fashioned approach, surgeon reviews path and radiology, may speak individually to radiologist, pathologist and asks oncologist's opinion; same as mdt but no group input, no cns input and more time consuming
21. The most important discussion is with the patient. In difficult cases, or where there are options should be brought to mdt, or discussed within oncology.
22. The designation "advanced disease" is a staging issue which is naturally discussed by the MDT. For obviously-inoperable recurrent disease discussion within the non-surgical oncology grouping should be sufficient.
23. Team meetings/ or pre/post clinic meetings difficulty with doing full MDT discussions is that this would bring the system to a halt, as well as wasting the time of professionals who very rarely have a role to play in advanced disease
24. standardised guidelines either nationally or local
25. specialist oncology meeting eg breast
26. Should be network protocol driven, if the circumstances do not fit into the protocols they must be discussed within an MDT. If the treatment is further lines of chemotherapy there is no advantage to discussing within the MDT when there is probably only one medical Oncologist available. Discussion of palliative patients for second or further lines of chemotherapy should be discussed with other oncologist no necessarily surgeons etc
27. shared decision making with patient and carers
28. responsible clinician/patient decision with advice from MDT if requested
29. regular dept meetings to discuss difficult cases, otherwise nos. are too large and decisions too st. forward to discuss at mdt
30. Reasonable for these decisions to be made by oncology/palliative care teams that work closely together
31. Provided good protocols/management pathways are agreed then every uncomplicated recurrence should not need to be discussed, particularly where there is only one treatment modality involved.
32. Protocols and guidelines. Clinical judgement and experience.
33. Protocol or local guideline based
34. protocol driven; agreed by disease orientated groups
35. Protocol driven decisions and discussion of options with patients. I don't think the surgeons would be able to discuss the merits of second line chemotherapy for NSCLC, for example, but there should be a local protocol to guide this...however, the ability to get these patients discussed at the MDT if it is felt necessary is important.
36. perhaps oncology/palliative case specific MDTs
37. Patients should be treated according to guidelines. Discussing all recurrences at an MDT would at least double our MDT and would be a waste of time. Only need to bring to MDT when multidisciplinary are required.
38. Patients not under oncology care should be discussed at MDT when disease progressing
39. patient dr consultation
40. options are usually limited, records may need to be retrospective as "interval presentations" of cancer are so frequent

41. Oncologists should use their judgement as to which cases would benefit from MDT discussion. Other members of the MDT should be kept informed of the management of recurrent/advanced disease and may request an MDT discussion if they feel it appropriate
42. Often in these cases the treatment options are limiting and relatively straight forward, and can simply be made in clinic between patient and physician, in the same way as so many other clinical decisions. Where treatment options are more complex, eg uncertainty re amenability of liver mets for resection, these cases should go to the MDT for review. NB - although i believe clinicians should be able to bring cases of private patients to the MDT, the contribution of the MDT (time and expertise) should be recognised and paid for appropriately. Also, the proportion of private patients discussed should not be excessive - if they make up a significant proportion of patients discussed, then a separate MDT should be set up within the private system.
43. not feasible for all patients with recurrence to be discussed and not helpful. patients who would benefit from discussion should and are discussed
44. not easy- in practice the best an MDT can do is suggest a possible approach- the final decision about what is right for an individual pt can I believe on be done properly by face to face discussion between pt/family and Dr- such decsions often cannot be protocol driven
45. Not all patients with recurrent disease should be discussed at MDTs - this is impractical and would overload all MDTs. Consultant judgement and experience and expertise can be used in many cases without referring back to MDT.
46. Need to be able to discuss difficult cases with other consultant colleagues. Need to have separate recurrent/advanced disease MDM to ensure there is sufficient time to discuss these pts.
47. More appropriate to discuss with other oncologists at site specific group meeting
48. Mini-MDT with oncologist, CNS and palliative care would be a better forum for pt with recurrence. A surgeon/radiologist/pathologist is not going to be able to contribute to a discussion about toxicity and merits of different chemo regimens. They may not have seen the patient for 6 months (or at all).
49. MDTs consistently miss the general clinical condition of a patient. It is appropriate for some recurrences to be discussed but not realistic for all
50. It should be left to the treating oncologist to discuss if there is active management involving surgery or other treatment over and above chemotherapy or radiotherapy. The discussion of every cancer patient with advanced disease would make the meeting twice as long. It seems appropriate to allow the oncologist to use their professional judgement.
51. It should be at the discretion of the treating oncologist. There are many of these patient and not enough time at the MDT to discuss them all. If the decision is obvious it does not need bringing back. If the patient is complex then they should
52. It is impractical to discuss every relapse in an MDT (particularly for the common cancers). Alternative model: agreed protocols for recurrence and advice on which highly selected patients should be brought back for discussion to the MDT.
53. It is impractical for all patients with recurrent disease to be discussed at MDT. Patients who may be candidates for curative salvage therapy should be discussed. Selection criteria for salvage therapy should be incorporated in management guidelines.
54. It depends upon the tumour site. For eg if H&N recurrence it can be salvaged by surgery so needs discussion in the MDT as opposed to an upper GI primary where treatment options are limited and MDT could just delay the treatment. It should be left to managing clinicians' judgement.
55. Internal case reviews within Oncology
56. Inform MDT retrospectively. Have agreed protocol which can be implemented, involve MDT if it is not followed, or if decision controversial.
57. In the ideal world it would be great to discuss all these patients, but this would mean all day MDms and unless there is expansion in the consultant numbers,

- this is not a viable option and these decisions should be made by the attending consultant when appropriate and informed by local guidelines.
58. If there were twice as many Consultant Oncologists, and unlimited time, MDT discussion would become feasible.
 59. If the information requires monitoring then maybe decisions can be documented in a structured paper form that gets sent to the MDT
 60. If it is a pure oncology decision the oncologist should make the decision, if mixed input is required patients should be discussed by the MDT
 61. if decision complies with network protocol in management of progression/ recurrence
 62. If agreed protocols or trials run in a unit this should be an option
 63. Ideally all patients with recurrence should be discussed but the MDTs I attend are so overstretched that they could not cope if all these patients were included
 64. I think the current practice of oncologists managing straightforward cases and only discussing complex ones at the MDT is the most efficient.
 65. I think all decisions should be subject to audit with review in protected time as part of overall audit of MDM
 66. In most cases there are clear protocols to follow for recurrence, and only cases where the clinician feels they need advice should be brought to the MDT, otherwise MDTs will become unmanageable, and we should concentrate our time on new diagnoses and complex cases.
 67. I am the only oncologist at my MDT. My surgical/physician colleagues are not qualified to tell me when to treat with chemo or not
 68. guidelines, peer review- 2nd line decisions are made realtime when you see the patient in majority of cases. only complex cases need to be discussed
 69. good clinical judgement of clinician looking after them
 70. following mdt agreed protocols
 71. Experienced oncologist assessing patient and discussing options with them. Involving multiple disciplines overwhelmingly unlikely to help unless specific issues eg. equivocal radiology.
 72. Discussion with other site specialist oncologists
 73. discussion with core members outside MDT
 74. discussion patient/ specialist nurse/ palliative care team & relatives
 75. Discussion of outside protocol decisions?
 76. Discussion by oncologists with other oncologists, specialist nurses, or palliative care teams in a smaller group could be considered. If treating to a protocol then may not need discussion except with the patient.
 77. Discussion at MDT of complex cases or those where more than one subspecialty could be involved. A mechanism can be set for case discussion amongst oncologists where the treatment options involve only chemo or RT
 78. Discussion amongst oncologists with that site specific interest
 79. discussing within the mdt the ideal, but the oncologist should be able to take appropriate action prior to that if timing would cause undue delay - in our network, we do have electronic / phone mini-mdts with 2-3 core members to discuss a specific problem that we would not want to wait for the next mdt
 80. Difficult cases should be discussed. eg 2nd line chemo or new RT treatment discussion with patient much more important than discussion with patient. MDT rubber stamping would prolong MDTs even longer and delay treatment.
 81. Difficult and challenging cases should be discussed. At present time constraints would make MDT unworkable if every progression/recurrence discussed. consultants should be allowed to make informed judgements as to which patients need MDT discussion for progression/recurrence
 82. Diagnostic MDTs as currently run could not cope with volume of oncological decisions of next line of treatment - a multidisciplinary clinic can be useful or oncological forum for discussion of difficult cases
 83. depends on the cancer type. But it is not practical for oncologists to discuss every single ongoing relapse/progression in every clinic. Only those that may need another MDT discussion or help. First relapses are brought to MDT. It is presumed oncologists know the feasible options for some tumour types.

- However for some tumour types most changes in management may need to go back to MDT.
84. Decisions that are multi modality eg more surgery/ radiotherapy plus chemo then MDT otherwise, the patients consultant should make a decision and involve key members as necessary. Specialist should be given responsibility to make a decisions as per usual professional practice. We will paralyse the MDT system with every relapse/ progressive disease otherwise.
 85. Could be listed at MDT rather than formal discussion
 86. could be discussed retrospectively
 87. Consultants will make evidence based decisions in the clinic. Often these are easy and clear decisions. If they are grey cases or need tests then they are already taken to MDTs. Mandatory discussion before decision taking will only cause distress to many patients. Most MDTs only have one or two medical or clinical oncologists and the other members know nothing useful to add to the debate.
 88. Consultant oncologist led with specialist nurse and patient
 89. Consultant based team decisions in the clinic or ward. Selected cases should be discussed by the MDT. Waiting for an MDM is not always safe or appropriate. Agreed protocols commonly define the appropriate course of action
 90. complex patients should be discussed. Our MDT would be overloaded with discussion of every patient at every recurrence/progression
 91. Clinical/medical oncologist to decide as long as the overall treatment pathways are agreed by the MDT
 92. Clinical based decisions according to protocol
 93. Clinic based decisions
 94. Clear guidelines for patients which should be referred back (for example, when evidence suggests more than one possible option involving more than one specialty)
 95. Bring them back to MDT for agreed reasons e.g. if there might be any possibility of further surgery, if the scans are contentious or complex, if the disease course is unexpected. The full MDT cannot routinely discuss every pt who has progressed on chemotherapy, and they don't need to. There can be oncology pathways to guide best care, and audit that pts are managed roughly in line with these. Eg surgeons won't have an opinion on the best type of 3rd line chemo to try - to force them to sit through such discussions would be a real retrograde step. It's the staging and early part of the disease where the MDT is so important, with an openness to bring back cases where clinicians feel discussion with the wider team of colleagues would be of benefit.
 96. BASED ON GUIDELINES
 97. Audit of cases should be sufficient, lots of reasons why it is impractical/not necessary to discuss at MDT
 98. as long as protocols are in place then these decisions don't need MDT discussion. If there is doubt regarding diagnosis then discussion is needed
 99. an oncology mdt
 100. All options should be discussed with the patient, including trials (whether these are available locally or not). The clinician should then work with the patient to determine the option with which the patient is most comfortable.
 101. all first recurrences or rec after "curative treatment should be discussed. progressive disease for pts receiving palliative treatment should only be discussed if oncologist / physician overseeing care feels it would be helpful.
 102. agreed protocols with indications, meeting with oncologists who all treat that condition meeting up and discussing cases -patients where non-oncological input required should be put onto the mdt
 103. agreed protocols where appropriate

What are the main reasons for MDT treatment recommendations not being implemented?

114 oncologists responded to this question.

1. You cannot make a firm recommendation in many circumstances without seeing the patient yourself to assess appropriateness of the delivery of your particular modality for that patient. I feel very strongly about this. Patients may decline when they know risks/benefits
2. When the MDT was unaware of individual patient factors; when the clinician responsible refuses to join the team or adhere to MDT decisions; where trial entry was recommended and the patient was found to be ineligible.
3. Usually no MDT member had met the patient prior to MDT
4. The true picture of the patient is not appreciated - often not fit enough for recommended treatment. Comorbidity, PS often under/overestimated. Fast track system often means no-one other than a nurse has assessed patient before they are reviewed.
5. The patient situation is found to be different from that presented at the meeting or the patient expresses a clear contrary view.
6. The patient isn't there, so the ultimate decision has to be between the clinician and the patient in the clinic, albeit a decision informed through the MDT discussion.
7. The patient is absent, comorbidity is difficult to assess and consent must be obtained
8. The patient has to be seen by the relevant clinician before the recommendation is endorsed. So in H&N there may be >1 option and discussion with the patient is needed to determine best approach. In lung performance status is critical and I often recommend a different treatment (eg RT not chemo) when I have met the patient.
9. The patient has not yet been seen by the treating physician (particularly where the main route of referral is the MDT) and the treatment is clearly unsuitable for the patient or does not accord with patient wishes
10. The patient saying no or the patient's physical situation changing making the decision made no longer appropriate
11. The decision was made in the absence of anyone actually having met the patient. Subsequently transpires that patient is unfit for MDT recommendation.
12. surgeons
13. subsequent recognition that the patient as sitting in the clinic is either wanting, or better suited for, a treatment than was recommended without the detailed clinical assessment
14. Some decisions can only be made having seen patient. Patient views. Not all data being available at MDT. This should not be seen as a fault of MDT
15. seeing the patient and realising that the MDT decision was inappropriate for a particular patient, eg because of patient choice or frailty
16. review the patient and their performance status is poorer than was discussed in the MDT
17. Relevant information not included at MDM. Performance status not assessed/wrongly assessed/changed since MDM. Patient wishes.
18. Recommendations deemed to be inappropriate when patient assessed clinically
19. recommendations being made without adequate info or no one knowing the patient and their views
20. PS not known at time of discussion at MDT. Patient referred to a clinician who was not present at MDT when case discussed. Co-morbidity not declared at MDT which makes suggested treatment risky
21. Poorer performance status of the patient than anticipated at the MDT
22. personal agendas and conflicting interests between core members of MDT
23. performance status of patient/ other medical issues not known at time of discussion
24. patients not fit enough or patient preference
25. Patients condition deteriorating, no longer fit
26. patients clinical state i.e. co-morbidity personal view etc

27. Patients' fitness levels and performance status.
28. patient wishes, poor performance status of patient when attends.
29. Patient too frail/unfit for radical/aggressive treatment recommended by a team who do not know the patient.
30. Patient subsequently identified to be unfit for treatment proposed.
31. Patient status, choice, co-morbidity
32. patient PS
33. Patient preference. Full information not available at mdt, and recommendation therefore not appropriate. Patient not fit enough for recommended treatment.
34. Patient preference
35. Patient preference
36. Patient opinion and fitness
37. Patient not adequately assessed prior to discussion so planned treatment inappropriate (sometimes disease has progressed since investigations performed)
38. Patient might decline advice incorrect information at MDT situation changed by the time patient is seen
39. patient fitness and comorbidity not known or effectively assessed and documented in notes. patient choice
40. PATIENT FACTORS: comorbid history/ PS/ Pt preference
41. Patient discussed when no-one actually knows the patient!
42. Patient deterioration / patient choice
43. patient declines treatment offered
44. Patient decision or patient too poorly, or patient deteriorates before recommendation implemented
45. Patient condition has changed. Patient choice.
46. Patient choice. Patient has deteriorated/ or improved.
47. Patient choice. Decision communicated too late, so different plan already implemented.
48. Patient choice. Patient's performance status/co-morbidity.
49. patient choice, poorer performance status than described, and unrealistic expectations
50. Patient choice, new information
51. Patient choice, ineligibility for trials, new information
52. patient choice, change of circumstance
53. Patient choice or patients who turn out to be unsuitable as a result of co - morbidities
54. Patient choice and fitness
55. patient choice and changing clinical situation as well as difference of opinion and who is then accountable in court.
56. Patient choice and also patient factors not available to meeting
57. Patient choice Previously undisclosed co morbidity Often an MDT makes a recommendation for an informed discussion, believe it or not we are capable of this and so there is not always a clear decision often one of 2 or 3
58. patient choice patients condition changes disagreement in mdt
59. Patient choice change in patient condition
60. Patient choice
61. Patient choice
62. Patient choice
63. patient choice
64. patient choice
65. patient choice
66. Patient characteristics were not presented at the MDT (particularly fitness and co-morbidities)
67. Patient being unfit in general for the proposed treatment. Patient doesn't want the proposed treatment.
68. Patient's performance status is worse than anticipated; patient choice.

69. patients unfit for therapy decided at MDT since case inadequately known
70. Once you see the patient you have to revise what is feasible. Or patient wishes are taken in to consideration.
71. once oncologist meets patient, it is apparent their performance status and/or co-morbidities would make the suggested treatment too dangerous/inappropriate - thus an alternative is discussed with the pt.
72. Often surgical - at operation it is discovered that the planned operation is not possible (disease not correctly staged) Patienty choice- often in head and neck the patient will decline a radical option
73. not knowing patient's performance status, ie. patient not able to tolerate planned treatment. patient preference
74. Not having sufficient information as to the patient's status and co-morbidities at the first discussion
75. Not appropriate when the patient is seen eg. less fit than thought, previous illness not discussed (eg. prior pulmonary embolus, so tamoxifen contra-indicated)
76. new information becoming available
77. Meeting patient shows they are not suitable for original plan (performance status / co-morbidities)
78. MDTs consistently miss the general clinical condition of a patient.
79. MDT unaware of additional clinical factors
80. MDT output is only as good as the input. Rubbish in equals rubbish out
81. MDT does not have patient wishes available. Recommendation may be inappropriate when patient actually seen by other members of team.
82. Lack of info on performance status and comorbidity or inability to complete whole of treatment plan due to complications of a stage in management
83. Care plans should be communicated to other health professionals in the treatment pathway within a locally agreed timeframe.
84. In some cases a choice has to be put to the patient so no one recommendation can be made. In other cases the general condition of the patient proves to poor for the recommended treatment.
85. Insufficient history (morbidity comeds) patient choice
86. Insufficient info about the patient's true medical state at the time the MDT decision was made e.g. pt not medically fit for surgery, or deterioration between the time of the MDT and the time of treatment, esp in brain tumours. Due to targets, surgeons often present cases of pts they have never met, to get them through the pathway fast enough, which isn't necessarily insurmountable, it just has to be accepted. Similarly, it has to be accepted that not all MDT decisions will be carried out, but the reasons why not should be recorded and fed back.
87. Inappropriate when the patient is seen by a doctor, something which does not always happen with direct two week wait to endoscopy, so the full clinical picture/ patient's preferences are not known when the case is discussed at the MDT.
88. inadequate or inaccurate information being presented at the MDT, and patient preference
89. if patient co-morbidities not known, or patient's wishes differ from MDT
90. Failure of the MDT to have comprehensive information (most often about performance status and comorbidity)
91. discussion with patient, co-morbidities of pt not discussed at mdt.
92. Disagreement amongst clinicians. There isn't level 1 evidence (not even level 2!) for every clinical decision made and in some cases there are differences of opinion. The MDM discussion centers on a presented case with very few members of the MDT having met the actual patient and sometimes MDT decisions need to be revised after clinical review of the patient or they may not suit the patient's wishes.
93. details of comorbidity etc not made clear to team for discussions
94. decline in performance status patient wishes
95. decisions made without full clinical picture
96. core member attendance on the day patient preference clinicians view if

- different from MDT view
97. consideration of chemotherapy is recommendation and often the outcome of an assessment is that the patient is not fit for chemotherapy
 98. comorbidity and performance status not being known at the MDT
 99. Co-morbidity Patient wishes
 100. Clinician doesn't agree with the MDM decision in the first place.
 101. Clinical situation has changed or was NOT ACCURATELY REPORTED TO mdm
 102. Clinical condition of patient when reviewed makes MDT recommendation inappropriate, patient choice.
 103. Clinical circumstance, physician bias
 104. clinical changes in patient mis-information given to MDT or recorded at MDT
 105. change in circ's
 106. Administrative
 107. additional medical information about the patient eg contraindications to specific treatments not available at MDT- often non-cancer PMH details, and patient choice
 108. Additional information post MDT
 109. Additional info comes to light that was not available or not discussed at the MDT
 110. A patient's performance status is often incorrectly portrayed at MDT
 111. A change in the patient's performance status.
 112. 29.1 Initial treatment recommendations should be discussed at MDT 29.2 Patient choice
 113. 1: patient choice 2: not all information available at time of MDT decision 3: other medical conditions that preclude MDT-decided treatment 4: unexpected findings at surgery.
 114. 1) Inaccurate information about comorbidity or performance status being presented at the MDT; 2) patient's wishes

How can we best ensure that all new cancer cases are referred to an MDT?

71 oncologists responded to this question.

1. via clinical nurse specialist ensuring all new patients on for discussion / presentation of all positive cancer pathological data - data collection must not be purely the MDT co-ordinators role particularly for issues such as co-morbidity.
2. USING the help of pathology reporting
3. Use the two week wait staff, and pathology and radiology staff to pick up patients referred in different ways
4. tracking
5. track through pathology reports
6. Through pathology
7. This is already happening as a result of Peer Review - however, the necessary resources (particularly if enhanced activities are needed such as audit) have not followed and need to do so
8. this can be difficult if the person who should bring the patient to the meeting decides to refer them elsewhere and no one else knows about it. can't ask cns as this puts them in difficult position. perhaps discussing at mdt should be a requirement.
9. This can be a problem! Depends on data collection and raising profile of the MDT within Trust
10. They broadly speaking are
11. the introduction of the MDT as a vital mechanism for decision making in management of cancer patient should be a part of staff induction in all levels of from consultant, registrar level (as there are medical staff coming from overseas)

- and are not familiar with the function of the MDT) to junior medical and nursing staff.
12. Structures established within teams / institutions
 13. Simple referral pathways and for the bad guys by the MDT chair informing the chief executive of all cases where it is discovered that patients were not referred. Needs firm policing
 14. safety net via pathology reporting systems
 15. Rules
 16. ROBUST REFERRAL PATHWAYS
 17. review against new patient clinics and pathology databases
 18. regular audit with feedback to relevant professionals if cases are missed
 19. Regular audit based on pathology registration
 20. recommendation that they are and audit
 21. recognition of the need for MDT decisions by all members of the core and extended team.
 22. proper resourcing
 23. Proactive tracking of suspected cancer cases and making MDTs work well so referring clinicians see the benefit of MDTs
 24. Pathways to catch all possible referral sources, making clear that the MDT discussion is non-negotiable and not optional. Even if treatment is started as an emergency, the case always comes to the MDT the next week - it needs to be clear that treatment can be started if necessary. Having battled viciously a few years ago to ensure that all cases, even the very straightforward ones, came through the meetings, we do seem to have got over this and as far as I know, allowing for unforced errors, all the cases are discussed in the MDTs I attend.
 25. pathology trawls each week. radiological trawls each week.
 26. pathology reports direct to mdt co-ordinator
 27. Pathology and radiology probably best placed to capture this BUT may be not be appropriate to discuss all cases in detail ie: some may just need registration
 28. Pathology 'Flags'
 29. Pathologists should be encouraged to flag up new cases at the relevant mdt. Education of peers, junior Drs and GPs
 30. Pathologist flags up new cancer diagnosis to MDT coordinator. Education of clinicians in other disciplines. Easy identification of MDT coordinators and referral mechanism.
 31. offer better service via MDTs than non-MDTs, and make it very easy to refer patients in! This will gradually persuade all clinicians it is worth their while. at the same time, if there is a clinician who treats patients outwith an MDT discussion on a regular basis, this should become a disciplinary issue after suitable constructive dialogue.
 32. not sure
 33. networking at all levels
 34. Need more data capture resource- this grossly under-resourced
 35. Mechanism needed for discussion of patients with unknown primary
 36. Make sure that there is a registry of new cancer diagnosis in pathology that the MDT co ordinator checks to make sure all are discussed. Development of a culture that makes it routine to discuss all new cases and unacceptable not to
 37. It is a requirement for consultants already. Pathology, radiology and other diagnostic services need to be alert and can sometimes pick up cases that are missed
 38. it is a moral responsibility of the treating doctor to present his case before embarking on treatment and if urgent treatment was started then to present the case ASAP for record purposes
 39. IT
 40. I think this already happens.
 41. I believe they are where I am involved
 42. hotline system to MDT coordinators would help. All histology cancers could be

- flagged up. But still some cases would slip through
43. higher profile of mdt
 44. Having the best opinions available
 45. Having a record of who they were would help.
 46. Have systems that record the MDT decision along with the delivery of treatment (easy in RT and chemo).
 47. Good data capture by one designated individual
 48. Good communication, clear referral pathway, approachable teams.
 49. follow blue cross, only pay for treatment in registered cases!!!!
 50. fast track referral patterns, histology reports
 51. Education, pathology, radiology both bringing cases with the diagnosis
 52. education of specialties histopathology and radiology flagging cases
 53. education
 54. educate staff
 55. Don't pay for the ones that aren't!!
 56. data support member
 57. Continually educate all clinical staff to bring all new cancer cases to the MDT
 58. Clear referral pathways and guidance
 59. Clear identification of roles of pathologist, radiologists and diagnostician to forward new diagnoses to the MDT
 60. By making it part of the job planning process that MDT's form part of the job plan and that referral to, for example, oncology can only follow an MDT discussion
 61. By letting everyone know about them
 62. By ensuring that all clinicians to whom patients are referred are active members of the appropriate MDT
 63. By educating all staff involved including SpR's and colleagues in non - oncology specialties.
 64. Automatic pickup from radiology and pathology
 65. automatic copy of cancer histology to co-ordinators?
 66. audit of pathways
 67. Audit new registrations of cancer or new diagnoses in histopath against patient lists from MDT
 68. already near 100% for my mdts
 69. All new cancer cases don't need to be referred
 70. all mdt should be easy to access. simple referral procedures. increased awareness of the mdt process.
 71. Agreed systems for identifying cases such as arranging for all malignant histology reports to be sent routinely to the MDT coordinators office.

How should disagreements/split decisions over treatment recommendations be recorded?

84 oncologists responded to this question.

1. we have not resolved this and our medical director is thinking about this issue!!!
Very difficult....a balanced argument should be recorded... in the end the treating physician makes the decision with the patient. If the decision is regarded as poor practice by the majority then that should be challenged and the best practice recommendation recorded as the MDT decision.
2. VERBATIM
3. ultimately it is about offering choices to the patient - therefore if decision is not straightforward patient should have full and frank discussion to guide choice
4. truthfully and also to patient truthfully allowing patient choice with facts
5. truthfully
6. Treatment options with morbidities should be explained to patient for their decision
7. this is difficult, it doesn't happen often. There's usually some free text on the form. I now write to the MDT lead with my dissenting opinion....
8. these are usually difficult clinical decisions for which there is no correct answer and this difficulty could be discussed with the patient to more explicitly involve them in the decision
9. There should be detailed documentation of points of difference . Ultimately the clinician involved with the patient must discuss the outcome of the MDT with the patient.
10. there needs to be mechanisms to arrive at a consensus, split decisions should be very unusual and recorded as such. the frequency of them should be audited
11. There are rarely right and wrong options, just choices about the way to manage a problem, each with its own set of pros and cons.
12. The responsible consultant is advised to consider the disputed options with the patient and feed back
13. The dissenter should be allowed to document their objection
14. The discussion should continue until there is total support for a treatment plan. Where the plan contains 2 treatments that may be equally effective this can be presented to the patient. The outcome (and patient choice) is recorded in the clinic letter.
15. the discussion should be summarised and the names of the main protagonists. It is also helpful to know which other members were present at the discussion.
16. That it was a majority decision / not unanimous
17. Recorded as split decision. Final decision made in discussion with patient
18. Recorded as both options with clear summary of the pro and con of each
19. record should reflect discussion
20. Record made in MDT summary that there was no unanimity but that a majority decision was reached.
21. record in MDT outcome including reasons given
22. Record as split decisions and patient should be made aware of options.
23. options to be discussed with patient
24. on the MDT proforma and also on patient's medical records
25. No. Consensus opinion is better. Recording splits may set individuals up for litigation and may lead to withdrawals for the MDT and a breakdown of the process.
26. narratively
27. Name names - Mr X says this, Mr Y says that. In a good MDT, people should be happy for the pt to see colleagues for a second opinion, and if there's disagreement, this is what should happen so the pt can hear both sides of the argument. But I do feel that ultimate responsibility needs to stay with the named treating consultant - I wouldn't feel happy with a situation of "I did it because they told me to...." - if the treating consultant isn't happy with the MDT decision, he needs to pass the pt on to a colleague.

28. must record if continuing disagreement over a decision between core members - on database with individual names
29. mdt has to make a decision. this is not an option
30. managed by the chair - eventually the MDT can record differences and it may be appropriate to let the patient know that there was not universal agreement.
31. majority rules if truly hung then documented and options discussed with patients
32. List of options discussed can be recorded in outcome, preferred option first, with reasons for decisions and factors to be considered.
33. Keep decisions anonymous to clinician but express there were two views on how Mrs X should be treated then list both and offer patient both and the best person to see her and discuss
34. In writing. Opposing views can then be put to the patient for discussion.
35. In the notes
36. In the minutes of the meeting
37. in the mdt proforma
38. in the MDT minutes
39. In my experience these are uncommon. If no agreement can be reached the disagreement should be recorded in a written minute of the meeting
40. in minutes
41. In hospital notes. Further discussion in MDT when patient choice identified.
42. in full, as these are the most telling and relevant in retrospect
43. In full and discussed with the patient. If it is an ongoing or recurrent disagreement it needs to be sorted out.
44. In free text
45. I think all decisions need to be recorded in free text - it's usually too simple to have a tick box form only. So split decisions can easily be recorded
46. In the MDM report.
47. I can't remember one that has remained unresolved!
48. honestly documenting both sides
49. Honestly
50. Generally there should be consensus. If not, then the majority decision should be recorded with the counter-view recorded also.
51. Formally in the notes and the wording should be agreed by all sides
52. Factually with the competing reasons given
53. factually!
54. Factually
55. Factually
56. Entry in MDT minutes
57. Does it need to be? Could final outcome alone be recorded with thought processes and rationale for finally choosing one option over another.
58. Documented on the mdt proforma so that it is clear who was in disagreement and the reasons
59. Different treatment options should be documented
60. Depends - if a member merely has a preference for one of two options and both have evidence base support, then it should be recorded as "patient has 2 options". If a member feels that he does not support one of the treatment options then this should be documented traceably - i.e. by name.
61. decision is responsibility of treating clinician disagreements should be minuted
62. consensus decisions or patient view taken into account
63. clinician disagreement should be recorded by name, unfortunately we had to do this in my previous job as we had a dominant surgeon who did whatever he liked despite guidelines etc.
64. carefully
65. by name,
66. by name and decision arm
67. both views recorded.
68. as they happen with names

69. As they are
70. As that preferably with evidence supporting each point of view
71. As such. With views of treating clinician highlighted
72. as such, usually the patient can then make the decision which is perfectly satisfactory
73. As such in medical notes/ MDM record sheet.
74. as such
75. as openly as possible. remember the discussion between the oncologist and the patient is the one during which any final treatment decision is made
76. As honestly and openly as possible and discussed with patients in the same manner. Medicine is grey not black and white.
77. as free hand in the data
78. As clear a record of the discussion with points for and against made in real time with the agreement of the discussants
79. As a weighted list of options.
80. As a range of options to be discussed with pt
81. All opinions and the names of those persons voicing them should be documented.
82. accurately!
83. Accurately
84. 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 and if possible, discussed at a later date following review of evidence

Who is the best person to represent the patient's view at an MDT meeting?

116 oncologists responded to this question.

1. Whoever has the best knowledge of the patient
2. Whoever has met them and discussed their views. NOT necessarily the CNS
3. Who ever knows the patient best.
4. whichever individual has been involved in their care + cns
5. Whichever health worker has developed the closest relationship it could be nurse in OPD, SpR, CNS or consultant
6. whichever clinician or specialist nurse has had the most contact
7. very difficult, either specialist nurse or DR who has met patient
8. usually this is the nurse specialist who has met the patient - or the referring diagnostician
9. Usually the key worker
10. Usually the Clinical Nurse Specialist will have spent time with the patient. But treatment options can be discussed even if no-one knows the patient....for example, for stage 4 SCLC surgery just ain't an option....options are presented to the patient, not a plan the patient must follow...The problem is, quite often we don't know the confirmed diagnosis or staging before the MDT (one reason for the MDT is for everyone to review the results) so if the patient was there it would be one way but an awful one of breaking bad news...."here's your scan and look at all the metastases....."
11. usually cns
12. Tumour specific CNS - if available
13. Those clinicians who know the patient BUT the absence of such a person should not prevent the MDT considering what options are, or more particularly are not, available to inform the person that will meet the patient.
14. thekey worker
15. their clinician
16. the treating consultant or member of their team

17. The referring doctor
18. The person who knows them best. This may vary for different patients.
19. The person who knows them best
20. the person who knows the p[atient] best- CNS or Dr
21. the person who has seen and discussed diagnosis with patient
22. The person who has most recently assessed them and discussed treatment options with them.
23. The person who has met the patient, ideally a clinical nurse specialist
24. The person who has met the patient
25. the person who has best assessed the patient- this will vary
26. The person who has already met the patient be it medical or nursing staff.
27. The patient but this is not practicable and would seriously affect the workings of the MDT.
28. The patient
29. The member who has seen the patient
30. The MDM usually defines options which are presented to the patient. This needs to be done first and it is inappropriate for the patient to wait another week for the MDM to decide whether it wants to argue with the patient
31. The consultant who has seen them in a new patient clinic and spent a minimum of 30 minutes talking to the patient
32. The CNS
33. the CNS
34. the clinician who has seen them
35. The clinician who has seen the patient.
36. The clinician who has seen the patient and informed them of the likely course of their disease and treatment.
37. the clinician who has met the patient
38. the clinician in charge of the case
39. The appropriate clinician or breast care nurse
40. support nurse
41. suitable treatment options need to be agreed and then discussed with the patient by the appropriate teams - surgery by surgeons; radiotherapy by clinical oncologists; chemotherapy by clinical or medical oncologists. If not done in this way the option will not have been fully discussed with the patient. As such presenting patient views at the MDT is likely to be misrepresentative and reflect bias of the person presenting that view.
42. staff who have met with pt
43. Specialist nurse. Consultant who has met the patient. Registrar who has met the patient.
44. Specialist nurse or other professional who has spoken to patient.
45. specialist nurse or clinician who has met patient
46. specialist nurse or clinician who knows patient
47. Specialist Nurse
48. Specialist nurse
49. specialist nurse
50. Specialist nurse - but this really is an impractical concept
51. someone with validated WHO PS, Charlson comorbidity score, knowledge of their social responsibilities and support and their preferences. I think it is better for the MDT to review the options with the full data and then go to the patient to discuss - too many papers tell us that patients get recommendations differently depending upon who they consult first
52. Someone who has seen the patient. If 2 options and not certain which is best then both clinicians should be involved
53. Someone who has met the patient
54. Responsible clinician/ specialist nurse
55. referring clinician or CNS
56. Probably the specialist nurse

57. presenting clinician who has viewed patient and specialist nurse
58. Person who knows them best
59. person who has seen the pt
60. person who has met them
61. Patients views difficult to include at MDM; but should be taken into account by clinician who speaks to patient about treatment options after the MDM.
62. patient's clinician
63. Often the specialist nurse
64. Often CNS/specialist nurse, but in practice, the professional present who knows the patient best
65. Nurse specialist/key worker
66. Nurse specialist
67. Nurse specialist
68. Key worker
69. it seems like the referring surgeon cannot remember the patient well (generalisation, i'm sorry), cns can be useful but are not always good at assessing ps or co-morbidity
70. It is often a Nurse Specialist, but need not be. Anyone who either knows the patient well or has communicated with someone who does know the patient can represent the patient's views. Also, the case can be brought back to MDT after the patient has been seen in clinic so that their views can be presented.
71. ideally more than 1 person - diagnostic clinician plus a specialist nurse. It would be an ideal world, and undeliverable in the NHS, for patients to be able to attend the MDT, since for many, the time taken to bring them up to speed with all the issues involved would probably grind the MDT to a halt.
72. I think the patient's views are not always needed in the MDT - they are part of the doctor patient relationship
73. I hope we all represent the patient. It should be the person closest to them - whoever has met them. The MDT tends to come up with a range of options, with some order of preference, so that whoever then explains this to the patient knows the other management possibilities if the one which was recommended isn't applicable / desirable. In practice, most pts still want whatever is recommended - pt involvement is important, and decisions need to be taken in partnership with the patient, but too much choice is onerous, can be confusing and undermines the dr-pt relationship, as it can be interpreted as the dr doesn't know what they're doing. I would vehemently oppose having pts at MDT meetings - we just couldn't get through the volume of cases. I don't think that would be an efficient use of time at all. We'd need to at least quadruple the length of the meetings. I am happy to do a joint MDT clinic (with the GP if you really want), after the meeting, for more complex cases, and that can be very helpful e.g. when outcomes with surgery and radiotherapy really are equivalent. I don't think involving GPs in MDTs is a good use of their expensive time, when their pt might only get 2 or 3 mins discussion, but it will take an hour of their time to sit in on that. Let's just accept that MDTs are teams of secondary and tertiary specialists who actually do know more about how to treat the disease in question than the pt or the GP - surely we can still say that out loud??? While ideally pts shouldn't be discussed unless there is someone there who has met the pt, one of my big worries is pts not being discussed for this reason, and therefore being left in limbo and experiencing delays. I prefer to discuss pts in a timely manner, accepting it's a bit sub-optimal, tasking someone with getting the ball rolling with a plan and finding out proper info and then re-discussing the case the next week, rather than just say ...no-one here to present.....next....I think that can be disastrous. We have to accept reality.
74. I am not sure what the meaning of "patient views should inform the decision making process" is. Surely decisions are based on the basis of evidence as much as possible and experience. It is our job to give patients the MDT opinion on what their therapeutic options are. Then patient's views come into deciding what option to choose or whether to have treatment or not, and not into deciding what treatment will give the best therapeutic ratio.
75. good physicians /surgeons and the specialist nurses

76. Either the clinician directly involved in their care or a specialist nurse who has met the patient
77. Doctors/nurse specialists who have met patient
78. Doctors and nurses
79. Doctor who knows them, their key worker, other staff involved in their care
80. Doctor who has seen and Clinical nurse specialist
81. Doctor who has personally met pt, and/or specialist nurse
82. Doctor or nurse who has met the patient and family
83. Doctor or CNS that has met the patient.
84. Doctor or CNS or other key worker. In practice meetings are all hugely overbooked and the factors listed above are not conducive to the timely running of an MDT
85. Doctor or CNS
86. Depends who has met patient by time of MDT
87. Could be a nurse, Doctor or other professional who knows the patient and is able to take part in discussion.
88. consultants and spec nurses
89. consultant responsible for patients care
90. CNS / consultant
91. CNS
92. CNS
93. CNS
94. CNS
95. CNS
96. CNS
97. cns
98. Clinical nurse specialist who has met patient. Clinician who has met patient.
99. Clinician who has met and talked to pt, or specialist nurse
100. Clinical nurse specialist.
101. clinical nurse specialist, or diagnostic clinician
102. clinical nurse specialist and clinician
103. Clinical Nurse Specialist & Doctor
104. Clinical nurse specialist
105. Clinical nurse specialist
106. clinical nurse specialist
107. clinical nurse specialist
108. clinical nurse specialist
109. Clinical nurse specialist - or clinician who has met patient.
110. Clinical Nurse Specialist or other Key worker
111. Clinical nurse specialist
112. CLINICAL NURSE SPECIALIST
113. Any clinician who has met the patient. MDT meetings as they currently stand are technical meetings. Ultimately the patient makes the decision not the MDT, due to time constraints outside the MDM.
114. All who have met the patient
115. A doctor who has seen and examined them and gained an idea of the patients concerns and preferences.
116. 31.1 but not within the MDT 31.2 issue often far too complex for this 31.4 yes not all info may be available (or should be) are we going to bring back every patient not fit for palliative chemo because the renal function is too poor

Who should be responsible for communicating the treatment recommendations to the patient?

110 oncologists responded to this question. In addition, 6 oncologists referred to the answer they had given to the previous open question (Q32).

1. Whoever within the MDT is best suited, it cannot be prescribed.
2. Whoever will be delivering the treatment. the CNS should tell the patient that the MDT decision is that they should see the oncologist/surgeon, they should not tell them they are going to have surgery/rt/chemo as it will be more distressing if they are then told they are not suitable. The MDT decision is a recommendation not an absolute plan
3. When the pt is next seen in clinic the decision should be communicated to them - so probably by the medical team but could be nurse specialist
4. varies with the complexity and significance e.g. pelvic exenteration should be medically led, "no further treatment required" could be communicated by any responsible team member
5. varies
6. treating clinician
7. Treating clinician / Key worker
8. This depends - if the patient is fully aware of diagnosis already, it may be appropriate for the Clinician who will provide the treatment to communicate decisions re treatment. For some patients this information maybe appropriately communicated by a specialist nurse (eg via phone, prior to clinic appt). If it has been decided not to offer a major intervention that has been discussed in detail with the patient, it maybe appropriate for the clinician who has already had discussions with the patient to communicate the information.
9. the treating consultant or member of their team
10. The team - can be doctor, nurse or AHP
11. The referring doctor
12. the referring clinician or specialist nurse if patient has been forewarned
13. The professional who they have already seen for the cancer- at least in general terms, specifics of the treatment recommendations should then come from the professional responsible for that part of the treatment
14. The primary clinician who saw the patient initially
15. The person most able to give information about the recommendations: if it's chemo, the oncologist, if surgery, the surgeon, etc.....
16. the key worker or clinician with primary responsibility
17. the key worker
18. The doctor who has put the patient onto the meeting
19. The doctor who's care they are under
20. The consultant or CNS involved in their care
21. The clinician who would be organising that treatment
22. The clinician who next sees the patient in an appropriate clinic
23. The clinician who has last seen the patient and taken the case to the MDT
24. The clinician who has been in charge of their care.
25. The clinician undertaking that treatment
26. the clinician responsible for the management plan action
27. the clinician or specialist nurse
28. The clinician or CNS who is currently responsible for the on-going care
29. The clinical team who next sees the patient and if different the team who will carry out the treatment
30. the clinician/nurse who has met them
31. The appropriate clinician
32. Team looking after pt.
33. staff involved nurse / clinician
34. specialist who will be initiating the treatment so that pros and cons are explained
35. Specialist nurse/ managing clinician
36. Specialist nurse Consultant

37. Specialist Nurse
38. Specialist nurse
39. specialist nurse
40. someone who has met the patient
41. responsible clinician although could be delegated to a senior CNS dependant on the decision
42. referring clinician and clinician undertaking treatment, jointly
43. Referring clinician
44. Referring MDT member responsible to inform patient of decision. Patient then to attend appropriate clinic with appropriate surgeon/clinician for full discussion on treatment option
45. primary dr
46. preferably the same person but in practice the clinician undertaking the next stage in management
47. preferably clinician but if patient prewarned we sometimes phone them after meeting by doctor, nurse or MDT coordinator
48. person who has met them
49. person next due to see them or whoever has agreed to contact them with the results
50. patient's clinician
51. Nurse specialist/key worker
52. Nurse specialist or person who knows them best
53. Member of the team who have previously communicated with them.
54. MDT coord books pt to the clinic of the person(s) who will be seeing the pts
55. lead clinician for patient
56. Keyworker
57. key worker - usually the clin nurse specialist
58. It will vary depending on individual circumstances.
59. It depends, usually the consultant team or possibly specialist nurses etc.
60. Ideally, the same clinician, otherwise someone more senior.
61. Ideally, the consultant looking after the patient. However, this is not always practical in a suitable time-frame. A Nurse Specialist is often a good liaison person with the patient.
62. Ideally the clinician who most recently has met the patient.
63. ideally a Dr- in practice often a nurse
64. doctors and nurses
65. Doctors and / or nurses
66. Doctor seeing the patient
67. Doctor or CNS that next meets the patient (ideally someone they know already)
68. Doctor in most cases as treatment will need to be discussed. Key worker needs to be there to follow-up. In some cases key worker can communicate.
69. doctor in charge of patient or support nurse
70. doctor in charge of case
71. Doctor and specialist nurse
72. Doctor and Clinical Nurse Specialist
73. Doctor
74. Doctor
75. diagnosing physician
76. Depends on what treatment etc is advised - most appropriate individual ie surgeon, oncologist, CNS etc
77. Depends on the outcome of the MDM. Whoever does this should have the competence to answer relevant questions that might ensue.
78. Depends on the decision and the previous discussions the patient has had regarding treatment
79. depends on the decision - will range from surgeon (eg for an operation), specialist nurse (eg. to say needs staging or to see another specialist), oncologist etc. GP needs to be informed as well

80. Depends on decision - nurse or doctor
81. CONSULTANT, CNS
82. Consultant treating patient or their deputy
83. consultant responsible for treatment
84. consultant responsible for patients care
85. Consultant or SPR with appropriate training
86. Consultant or SpR or sometimes CNS
87. Consultant at next appointment usually unless alternative eg phone call has been agreed in advance
88. Consultant
89. Consultant
90. Consultant
91. CNS, research nurse, treating physician.
92. CNS or doctor
93. CNS or cons
94. CNS can often do this but it is better if the patient can see the consultant who will supervise most of their treatment
95. cns and perhaps copy letter form mdt lead or person who referred patient to mdt
96. CNS
97. Clinician with specialist nurse support
98. Clinician seeing patient next in the pathway with the specialist nurse
99. clinician responsible for making decision and specialist nurse if treatment is to be given. If it is clear patient is not fit for surgery or chemotherapy the referring clinician should be able to have this discussion with the patient
100. Clinician patient is being seen by or allocated clinici nurse specialist
101. clinician
102. clinical nurse specialist or consultant
103. clinical nurse specialist can inform patient of preliminary decision and patient should be seen and fully assessed and potential treatment discussed by relevant clinician.
104. clinical nurse specialist and clinician
105. CLINICAL NURSE SPECIALIST
106. clinical nures specialist
107. Again, whoever is closest to them. We try to set it up so the pt will come to a clinic a day or 2 after the MDT, so that that Dr will convey the info to them. Otherwise, I guess its the specialist nurses.
108. a person they have already met who informed them they would be discussed by MDT. This can be a phone call to say "they discussed your case and you'll be hearing from the oncologists to see them and discuss possible options" for example
109. a nominated person at the mdt, dependent on whether this need to be done by phone or in person.
110. a named key worker identified at the MDT

Measuring MDT effectiveness/performance

What other measures could be used to evaluate MDT performance?

40 oncologists responded to this question.

1. You can only measure performance if they equality of access to Rx
2. Which clinicians are present each week and to whom the patient is referred
3. time of meeting as a fraction of number of cases discussed
4. test cases - nationally set case to be discussed at each mdt and feedback
5. survival not useful in poor prognosis tumours - e.g. lung. MDT members opinions; peer review; number of 're-discussions' because of incomplete information particularly
6. Staging, improvements in dataset collection. Survival rates are difficult, I don't know whether this will be improved solely by MDT working. Patient satisfaction survey tend to be sensitive to the communication skills of the staff not their MDT working. Trial participation depends on many factors outwith MDT control (whether the CRN agree to support the trials, etc).
7. Resources wasted in unnecessary tests and treatment.
8. Record of completeness of documentation None of the above measures is likely to have any statistical validity
9. Proportion of patients treated according to guidelines, by appropriate doctors and within appropriate timelines
10. Proportion of decisions recorded in case notes.
11. please don't add to targets and metrics and bureaucracy. Probably the best thing would be to arrange peer review whereby random MDTs are recorded, and a peer review team reviews the recordings and then engages in discussion with the MDT.
12. Please don't add to the already huge burden of data collection by trying to collect data on this! I cannot imagine that this will be effectively measurable!
13. percentage attendance of core members
14. peer review
15. Patients discussed per unit time
16. NUMBER OF REFERRALS
17. Number of complaints from patients regarding their journey.
18. Number of cases not discussed due to absent information
19. none of your choices look relevant! They aren't usually in the MDTs power. the real role is to double check data (cancer stage, type, etc), after that we have such strong treatment guidelines that the rest is down to local treatment resources and skills. this is why data on centralised services shows no improvement in outcome - the real step is in evidence based management plans, eg NCCNs algorithms. Some NHS R&D research would be money well spent; how many staff hours are lost for MDTs each week and are the decisions made any different in the end? If no - then consider other ways to enhance education and teamworking that may offer better value for the NHS cash
20. None of the above! I think it is very difficult to measure MDT performance.
21. none of the above seem useful
22. None of above!
23. none of above can realistically measure effectiveness of MDT
24. No other measures This will just detract from the already huge burden of targets which we must attend to
25. Monitoring adherence to treatment guidelines
26. Maslach Burnout Inventory on staff! Satisfaction survey of referrers Audit within the MDT of results (which would be more useful and less confrontational than benchmarking against other MDTs)
27. internal audits
28. Implementing these measures requires resources. Enough!
29. I suggest that the above suggest unreal expectations on someone's part!

30. effective time management ie showing efficiency in allocating adequate discussion time for complex cases and swift decisions re starighforward cases with an agreed management pathway.
31. Decrease the number of man hours of attendance time per decision by limiting membership to those who contribute to decision making (e.g. why have 3 gastroenterologist or 4 surgeons at a meeting when they could attend in rotation?)
32. Cancer target times, patient satisfaction, trial accrual, all the above
33. Benchmarking against clinical guidelines Satisfaction of members with the meeting/team Other outcome measures - complications, side effects etc
34. Audit as to whether all patients have a clear plan from the MDT which fits in with recommended protocols of practice
35. Any measures used for comparison between teams should reflect casemix
36. A list of key aspects of the MDT process should be devised, and the MDT should be assessed to see if it consistently satisfies these procedural steps / items
37. 30 day mortality following MDT-recommended decision. Patients' understanding of their treatment plan.
38. 1. peer review of the MDT and its functioning. 2. confidential assessment of the views of the specialist nurses as to whether it works in the interests of patients.
39. ?morbidity/mortality reflect appropriate case selection
40. % of patients treated according to the MDTs guidelines on each stage of disease

Supporting MDTs to work effectively

What one thing would you change to make your MDT more effective?

82 oncologists responded to this question.

1. timetables lunch provided as most are stuffed in between other tasks at lunchtime
2. time other than over lunch time. Mid day scramble between other commitments is commonplace for all members of certain MDTs
3. There should be more detailed documentation for complex cases , summarised at the meeting by the clinician who will next see the patient but for all to see / hear to ensure that this reflects the full nature of the discussion and when there are differences of opinion.
4. Teach team working to one or two members. Very difficult if you believe you are always right.
5. successfully persuade one of my colleagues that there are occasions when silence is golden
6. Strong leadership
7. stipulate that only histologically proved cancers are discussed
8. Speed up some discussions
9. small amount of time to allow preparation of cases for discussion by me.
10. Rotate the chair as if the chair is inefficient, the whole meeting is prolonged and inefficient
11. Room layout
12. replace one of the core members who has been difficult to work with
13. reduce number of patients discussed
14. punctuality
15. Proper allocation of time - not lunch times or where there is overlap with clinics/theatre
16. preparation time
17. physical presence at the mdt
18. patient centred data available - WHO PS (Karnofsky seems the most reliable), validated comorbidity scale (Charlson probably the most reliable in a short time), and an ADL assessment

19. Organisational issues, mostly related to access and availability of scans to be reviewed (CDs with images go missing in the post far too often with consequent delays) and preparation of the meeting. Ensuring that patients are presented by a member of the team who knows the patient.
20. One MDT is effective and continues to move forward. The the other having been at the forefront of local MDT's has not changed for sometime and is disrupted by members with a transmit but no receive mode. It need strong leadership and this is not currently apparent.
21. Not squash it into lunch hour
22. not show images/pathology specimens for straightforward concordant breast cases which completely and easily fit treatment guidelines
23. Not being rushed
24. nominated chair, time to discuss new developments
25. moving from an extended luntime to a proper half-day
26. More time per case
27. More time for discussion
28. More time
29. More time
30. more structured discussion to allow non-medical team members to make equal contributions and make sure that no-one had been overlooked.
31. More focussed chair
32. more engagement of clinical lead
33. More administration support
34. Make the meetings less surgically focussed
35. Limit discussion to those cases where discussion is needed and restrict discussion of cases where treatment decision is clear and uncontroversial.
36. lead clinician needs to work in order to convince the other core members he works with them and not against them. Make sure there is an enviroment members feel secure, there are no secret politics and hidden agendas
37. IT help for every meeting!!! Or better IT
38. IT and data support
39. Increase frequency of visiting specialist attendance (or videoconference).
40. in Head and Neck: Give it more time in Breast: change the management
41. improvement in video-conferencing part of the MDT which delays things. keeping to the point -not going into too much detail which doesn't affect either the patient or other members of the mdt
42. Improve the IT
43. Improve quality of referrals through network-wide communication (to be implemented and audited soon).
44. Improve IT support for data collection
45. If the doctor presenting the case has always met the patient!
46. if all members are present at all meetings
47. I would insist that patients cannot be discussed in the absence of someone who has met them
48. I would have the Trusts made legally responsible for MDT meetings to take place and for relevant clinicians to attend.
49. I work in four. Two are good, the third has too much work for the time, the fourth is dysfunctional because of disinterest on the part of the pathologist and radiologist and intermittent attendance of core members. The most important thing is that all members feel that the MDT is relevant to them.
50. I attend 6 mdts - the one that works best has had the earliest input of admin support plus early and respected involvement by the clin nurse specialists
51. have more time to discuss patients properly
52. Have a summary of each case ready prior to the meeting to reduce the time wading through the notes
53. get rid of videoconferencing
54. Ensure patient list, with brief summary of case, available at the start of each mdt.

55. Ensure all information is available, that someone has seen the patient and that all members are able to attend
56. Double reporting of pathology
57. dedicated support responsible for kit functioning
58. data manager support
59. data collection support in terms of man power and IT
60. Compulsory group education around the topic, in a social environment! (ie beers! Sorry, but it's true!)
61. complete each case with summary of decisions
62. Coffee
63. coffee
64. change time so that i can improve attendance rates
65. chairmanship
66. Chair it effectively
67. cannot answer since I go to 5 of them! I think probably better organisation is the commonest issue.
68. bring more patients with recurrent disease to the MDT, and enable some patients to be seen immediately afterward by a team of clinicians (i have experience of that at a previous hospital)
69. Better videoconferencing equipment
70. Better technology and expertise in use Time for reflection - special meetings for audit and M&M
71. Better qualified doctors with specialised interests, conducting cutting edge research.
72. Better preparation
73. BETTER PHYSICAL CONDITIONS FOR THE MEETING. BETTER RADIOLOGY TELEIMAGING
74. Better IT support
75. Better Chairmanship
76. Better chairing of discussion.
77. Better chair
78. Appoint a good chair to lead the discussion.
79. An increased amount of time in the day!
80. allocated job plan time
81. Agreement from all on how to organise the meeting and the roles
82. adequate administrative support, clear list of cases to be discussed and reasons for discussion.

What would help you to improve your personal contribution to the MDT?

61 oncologists responded to this question.

1. we already have a quarterly MDT educational/management half-day. very helpful
2. time!
3. Time to share experience and knowledge (we used to have a 'lessons learnt' section at the end of the MDT but because of the case load this has had to be sacrificed.
4. time having chairs who do not simply think that "refer oncology" is an outcome and allow discussion re treatment modalities and trials. some of my MDTs are very productive- others arenot
5. time to keep abreast of new advances - this could be attendance at courses or personal reading of journals
6. They would be during core hours and therefore take the stress off attending meetings that start at 8am and are therefore family-unfriendly. Providing lunch would help for those 2 mdt's that are during the lunch period
7. The MDT enables review of pathology and imaging. The emphasis should be on making an appropriate decision for each patient discussed. There are other, less time pressed, forums to share learning and best practice.
8. The MDT chair should ensure that the MDT itself provides training as it functions. Spending resources on separate trining is unlikely to be as effective and will be expensive and distracting from more important work
9. Switching to Internet Protocol-based conferencing.
10. Space to discuss the implications of recent research on clinical cases
11. Some time to prepare cases for discussion
12. patient factor data reliable PACS images rapid reporting of results (2 week waits are not easy to manage)
13. Not having to video-conference
14. More time.
15. More time.
16. More time to read journals
17. More time to prepare where I chair. More involvement in those I do not
18. More time to go to the MDTs!
19. More time so I can attend the entire MDT as well as my clinics. 2 of the MDTs I am a core member of run concurrently.
20. More time on site, rather than travelling between hospitals
21. More time in my jobplan
22. More time in job plan to attend/prepare
23. more time in job plan
24. More time for CPD to keep up to date with developments
25. More time (SpA) to keep up with all the evidence base for decision making
26. more time
27. more time
28. more time
29. more time
30. more time
31. more patience with colleagues who make inappropriate recommendations either when they don't know the patient or when they don't know the evidence base.
32. Less pressure of time, i.e. no clinic immediately before or after MDT
33. Less cliqueness between members who sahare a private practice - less insecurity amongst surgeons who feel they cannot be challenged in public
34. Increasing my knowledge with regards to my cancer site and being involved more in the care of the patients are being discussed
35. in breast dividing the MDT with only post surgical cases for oncologists. In CNS videoC that works in H&N reducing number of FU scan reviews
36. In an ideal world there may be more time in our job plans for the supporting

- activity to background read and educate as well as take more interest in the working management of the MDT, this tends to be left to the chair.
37. If the renal cancer cases were sometimes presented at the beginning instead of the end
 38. if i knew the members better
 39. if everyone takes the MDT seriously
 40. having time to have lunch first
 41. Having the time to go to courses, conferences, doing cpd and cme.
 42. Having more time, feeling less rushed
 43. Having fewer better quality MDTs
 44. Have more time to prepare for them and spend time after them discussing difficult issues.
 45. Good organisation and good input from colleagues
 46. Fewer people in them. Surgeons improving their listening skills!
 47. Even reading this survey has raised issues. Online learning on good practice would be useful.
 48. DISCUSSING ALL CASES IN WHICH i AM INVOLVED CONSECUTIVELY
 49. Different for different MDTs. Some have weak leadership and this is the most glaring omission for those MDTs
 50. Dedicated time
 51. coffee
 52. better timetabling
 53. Better outcome data
 54. being valued as a team member and not dismissed
 55. being able to clearly communicate with the team
 56. allow time for greater discussion and hence learning. Trouble is, if we discuss patients more slowly we'd spend all our time in meetings and none of it with the patients which is what we are really about!
 57. Allocated time ...one MDT I attend has a full allocated session. Both of the others are over a "lunch time" between commitments which is not ideal.
 58. Advanced notice of patients to be discussed
 59. Acceptance in the Trust that minimum standards must be met.
 60. A realistic timetable so I could get there. Agenda circulated prior to meeting so I can prepare.
 61. A less hectic job plan so I could guarantee getting there on time and not having to rush off to another meeting.....

What other types of training or tools would you find useful as an individual or team to support effective MDT working?

28 oncologists responded to this question

1. What lesley fallowfield has done by sitting in, interviewing members, and then having a feedback at an away day. People, not electronics, are probably the best way to understand an MDTs strengths and weaknesses
2. we need more time to do the job properly not time taken up with training of uncertain or unproven value
3. We need fewer, better organised MDMs occurring within working hours. We currently spend large amounts of time sitting in MDMs listening to discussions on patients being repeated and MDM time spent is often wasted because outcome is not properly recorded. This is hugely frustrating and ineffecient.
4. Visiting other "beacon" MDTs to observe their functioning
5. Visiting effective MDTs as an observer
6. Training/access to cancer database
7. Training videos of 'How not to do it'

8. Training on how to use Videoconferencing (we have been using for 2 yrs but no training!)
9. Train the chair to make the process one of continual training and record keeping review
10. The opportunity to see how other MDTs function.
11. The most important training is to keep learning by reviewing up to date journals
12. support professionalism rather than the perception that the NHS wants it destroyed/ time at work to learn and reflect
13. Spend some time with coordinator to see what he/she does, which will improve referral quality.
14. peer review sitting in on an mdt or two
15. not sure
16. None will be effective until sufficient resources are available to pay for the time involved
17. none
18. National statistics re treatments and outcomes
19. it seems to me that the proverbial mountain is being made out of a mole hill here; it is not difficult to make mdt work, we should audit outcome, have sanctions if clinicians are not contributing appropriately but this seems unnecessary
20. I don't see these as being associated specifically with MDT working. I have answered on the basis as of methods have I found. or believe to be useful in a much broader area I have a concern about the emphasis on the mdt this appears to have as a focus for all high quality patient activity. MDT working has already weakened working relationships that are not grouped in this way - eg radiotherapy, delivery of chemotherapy and presumably similar radiology and surgical issues
21. Group education, re-education and continuing education about the disease, as I think many disagreements come from lack of knowledge / understanding of other's perspective and over-high expectations - a chance to benchmark against others levels of expertise I think would help.
22. Formal team training sessions as developed by Lesley Fallowfield and colleagues
23. Don't think they'll help
24. Critical appraisal by external observer
25. communication skills and personal psychometric testing
26. Communication skill in dealing with difficult colleagues. Effective management in dealing with 'rogue traders' - those colleagues who do not and will not engage with the MDT in a constructive way - occasionally you need a stick as well as a carrot!
27. away day proved most valuable - need educational update and process development update
28. ?

Please provide details of training courses or tools you are aware of that support MDT development

23 oncologists responded to this question.

1. Pelican rectal cancer course
2. Pelican course (Basingstoke) for management of rectal cancer
3. pelican centre training for colo-rectal mdt
4. Pelican centre courses for colo-recatal MDTs 3 years ago.
5. not sure
6. not aware of any
7. none
8. none
9. none
10. none
11. nil
12. Mentoring schemes for members that have to endure dysfunctional behaviour from other team members during meetings
13. Lesley fallowfield courses & Pelican course
14. Lesley Fallowfield as above
15. Lesley Fallowfield and team
16. I wasted 2 vital days of my life in Basingstoke
17. CRUK Talking with Teams About Trails course
18. Courses again!!! Will it never stop!!!
19. communication skills course, pelikan course (not particularly helpful)
20. Basingstoke colorectal (well intentioned but ineffective because it didnt impart new information to our team)
21. Attend the ASCO annual meeting, nothing is more educational
22. annual education day cases presented to 2 MDTs in neighbouring regions to compare decisions and identify varriance - which will be useful to audit
23. ?

Final comments

Please insert any final comments or observations on the characteristics or indicators of high-performing MDTs and appropriate measures of performance

35 oncologists responded to this question

1. you have not addressed the question of the actual and demonstrated commitment of individual trusts to the data collection process. Most give it lip service and pass the buck down the organisation. The question is do MDT members feel supported by their trusts in this area. In this network it is a resounding no.
2. While the existence of MDTs is very important, the 'output' of MDTs should be high-quality information to guide clinical decision-making, rather than making clinical decisions themselves. The final decision should always be made by the patient in collaboration with their doctor.
3. Visiting other MDTs to compare might be useful for all members.
4. Vigorous discussion is vital for good MDT - quite and quick MDTs are not challenging individual opinions - heavily surgically dominated MDTs are the worst in my experience
5. to implement all those very valuable and solid questions listed above need a plenty of time and probably more than one hour and this means in reducing the number of patients we are dealing with as we are well above the average quota in the whole of Europe and that leaves us with limited time to spend on preparation, attending the meeting and implementing the decisions.
6. The MDT has become an over-rated meeting. Most decisions can be made quickly between the treating surgeon/physician and oncologist. I now have colleagues that spend half their life in MDTs and are then too busy to treat any patients
7. The essence is in high quality data recording and review at audit. MDTs should be continually self-training as part of their daily processes
8. Resource, resource, resource. Too many MDTs have been established with no review of job plans and inadequate resources for secretarial, coordination and data collection functions. Increasingly, more data output is required (per NCIN) with inadequate resource to enable this.
9. Patient satisfaction - completion of LuCdata database
10. Personalities play a huge part - in my 2 MDTs, the pathologist in one, and the radiologist in the other, both believe that their contribution is the most important and insist on showing all images/specimens regardless of the relevance of the decision being discussed. This has tried to be addressed in both for many years without success - a strong leader is required to do this
11. One measure of performance is attendance, MDT meetings that work well are attended whilst those that don't work well are avoided, making the matter worse.
12. one good MDT takes along time but at least I feel the case gets a decent discussion rather than a brief conveyor belt approach but it only happens because all the clinicians involved take a patient centred approach and it is not usual in my experience of MDTs. It is very much dependant on the individuals. However it takes time and means other aspects such as data collection are not as well supported.
13. Mega-MDTs should be avoided. Centralised MDTs should only take place where the Network's whole caseload can be discussed in 90 minutes once a week.
14. MDTs need radical change. Patients on clear agreed pathways should not be discussed merely recorded. This leaves time to discuss complex cases.
15. MDTs need adequate resourcing if they are to function well. This is not the case at present.
16. MDTs are here to stay and we must make them as efficient as possible
17. MDTs are about more than MDT meetings. MDT clinics are extremely satisfying, but they almost only ever occur where the team is really working well together.
18. MDTs achieve very little and could achieve more if we only discussed grey cases in more detail

19. MDT forum is useful but ultimately treatment decisions should be made by treating clinician in consultation with patient and family, ensuring that proposed treatment is appropriate and safe
20. mdt co-ordinators need to understand what they are doing and be proactive
21. MDM's vary enormously in their structure - breast MDM works well without a clear leader, Brain has strong permanent leader, H&N has a slowly rotating chairman but several deputise when he is away
22. Main problem of all MDTs I attend is not enough time for the numbers of patients we have listed. The amount of time spent by oncologists in MDTs is already a significant part of the week. It is essential that this very expensive time is used optimally to discuss patients where discussion is needed. All new patients should be recorded and discussed, some recurrences where treatment moves from curative to palliative - but not all (ie if next treatment is clearly defined / protocolised fo4r example prostate when it becomes metastatic). And cases that a member of the team feels needs discussion.
23. Leadership is key - IT is second key....
24. It would be instructive to cost the work hours of MDTs, and see what value for money they give. I enjoy them for the reasons of CME, team support etc, but find the evidence for their overall benefits in outcomes (OS, QOL and Cost effectiveness) lacking. Would a national guidelines network in cancer offer similar benefits for less cost?
25. It's fine to try and improve MDTs. The reality is, though, that resources in the NHS are limited, and it is unlikely that time-consuming improvements will ever be implemented.
26. Interaction between clinician and patient remains the most important aspect of care
27. I think that MDTs have revolutionised cancer management in the 10 years I have been an oncologist and I think that they are absolutely vital. My only criticism of them is that they can lead to a situation whereby decisions are ONLY be made by MDT; this can paradoxically slow up patient care as team members wait up to one week before making a decision.
28. I think its excellent that this work is taking place. We have carried out local research into MDM functions and the way meetings operate (and need to operate) is very different for each body site. You can't produce a one size fits all solution. I think too much of the discussion (and this questionnaire to an extent) focusses on the meeting not the team. The meeting is a vehicle to develop a good team. I don't think you need to have every patient discussed at a meeting for many tumours (skin, breast, colorectal) where treatment can be protocolised. Our breast MDM discusses patients for average 90 seconds - and rarely changes management plans. I think the value of a 2 hr meeting discussing 60 cases with 20+ consultants when the decisions don't change has to be questioned! As long as patients are managed (treatment, pathology review, radiology reporting) by MDT members I don't see why every case has to be formally discussed at a meeting. On the other hand our H&N MDT discusses patients for 5-10mins each and is invaluable prior to meeting the patient. So I would like to see a focus on the team not necessarily on the meeting, particularly as teams become established and become cogniscent of others' roles. In British Columbia each tumour site has a tumour board - 4 cases discussed in 1 hr with time to examine the patient during the meeting if need be and to see them straight afterwards. So the 4 most challenging cases (videolinked across 4 centres) are discussed. It would be impossible to discuss all new cases (and unnecessary as excellent teams exist - but they don't all need to meet face to face each week. So lets promote the importance of an excellent team - but not necessarily through (inevitably) longer meetings to ratify obvious decisions.
29. I remain doubtful, given the amount of time and resources put in , and the amount of benefit to the patient. Is it proven? Before the MDT the key consultants held joint clinics and talked about the same issues in less time.
30. getting and keeping the best coordiantors is vital!
31. For breast MDT's one measure is the incidence of "missed" breast cancers - a good MDT will review films etc and be sure that the right lesion has been biopsied and that a lesion hasn't been missed.
32. As a member of far too any MdTs,if i can be of use in looking at Mdts functioning

please let me know

33. all members get on and feel equal partners
34. Adaptable core members
35. A well-running MDT meeting is brisk, efficient, and good-humoured with laughter and education, even if this is cancer. I am lucky enough to be part of 3 such groups. We musn't do anything to jeopardise that e.g. tie it up so tight with rules that professionalism is stifled. But more support esp around communication, negotiation, confict resolution, team- working could be helpful, and more recognition for MDT chairs and co-ordinators