Chapter 4 - Findings

This chapter presents the findings of the research. It will not include a detailed discussion of the findings as this will be discussed in the next chapter.

In total 12 subjects were recruited into the study: ENT surgeons (2), maxillofacial surgeons (2), cancer nurse specialists (2), oncologist (1), radiologist (1), SLT (1), dietician (1), anaesthetist (1) and physiotherapist (1). Six potential recruits did not complete the study, and the universal reason behind this was lack of free time to attend the interview. They were a pathologist, a SLT, two cancer nurses from peripheral hospitals, a maxillofacial surgeon and an ENT surgeon. No one refused to participate in the study due to ethical reasons. All the interviews were transcribed and sent to each participant to validate. All subjects returned their transcripts, most without any change to the original.

An initial open question was asked about their perception of the function of the MDM from their own point of view, and then their own role within it. After the initial interviews, theories emerged from the data that were then incorporated into the following interviews.

Sections of transcripts are presented within the following text, and are represented within inverted commas. The subjects are given numbered codes 1-
12 in italics and parentheses in order to maintain anonymity, and the key can be found in the Appendix.

**Themes identified**

There were 6 themes identified. These were the role of the professionals at the MDM, the function and benefit of the MDM, disadvantages of the MDM, influence of the joint clinic, reasons for non-contribution (if relevant), and the ideal MDM. There were many sub-themes identified which will also be described.

**4.1 Role of the professionals at the MDM**

All the subjects described their role at the MDM. The term non-clinicians is used here to represent the views of those who do not have overall responsibility of head and neck cancer patients i.e. those other than Consultant Oncologists and Surgeons (the clinicians). The clinicians' role at the MDM was to discuss and plan their patients' treatment with the rest of the team, including other surgeons and the oncologists. Their role was also to ensure every patient was presented at the MDM to maintain the head and neck cancer patient database, and to encourage audit. The role of the non-clinicians varied and so will be discussed further.

**4.1.1 The role of the CNS**

The nurses' role had changed over time. In the beginning their role was administrative, involving collecting scans and case notes together. They felt their role had changed for the better since the introduction of a designated MDM co-
ordinator to do the administration work. Their role now was to represent patients’ views to the rest of the MDM, to the benefit of the team and the patients. This was summarized by one of the CNSs:

‘Our input is more clinical and hopefully if we have anything to say about the patients or if we’ve met the patients and we’re able to verbalize their views and just generally assess their situation, very often then that can be a benefit to the MDM.’ (1)

However they reported that their role in the MDM was limited. They did not contribute enough to the discussions even though they would like to. The reasons for this non-contribution will be fully discussed later (see chapter 4.3.4).

4.1.2 The role of the dietician

As well as to highlight the nutritional status of patients at the MDM, the dietician’s role had been to educate the members of the MDM into the importance of nutrition. It was now ‘automatic’ to consider nutritional status - oncologists would refer for PEG (Percutaneous Endoscopic Gastrostomy) insertion earlier if the patient was to undergo chemoradiotherapy, instead of waiting after treatment when there would be more complications. Clinicians did not need prompting in order to consider nutrition in a patient, and if they did it was usually only a gentle reminder.

She also found it was the only opportunity to discuss problem patients with the oncologists and other specialist nurses from peripheral hospitals. This was especially useful if patients at other hospitals were having difficulty with feeding.
This was something she could not do efficiently in clinics because there were too many Consultants per clinic. As she stated:

'I find it's a struggle in clinics being only one dietician to something like 5 Consultants. So I don't really get to see them because I'm just going round too many.' (6)

4.1.3 The role of the SLT

The SLT role involved advising clinicians as to the impact the proposed treatment may have on a patient's functional ability (with regards to swallowing and speech). She reported that she did not often contribute to the discussions which will be discussed later (see chapter 4.3.4).

4.1.4 The role of the physiotherapist

The physiotherapist was unfunded to attend the MDM, but found going to it vital to perform his role in the team. This was mainly to plan for patients who would require equipment post-operatively and to discuss with Consultants different surgical options with regard to functional outcomes. This was particularly important if free flaps were to be used as some of them caused more disability than others. This was the area that the physiotherapist would contribute in the discussions as is highlighted below:

My "contribution often is with regards to using certain types of free flaps that we use with patients and the actual impact on function and disability that might have on a certain patient. So really discussing with the Consultant whether one flap is more favourable than another with regards to outcome not only from a head and neck treatment point of view for reconstruction but also from a functional quality of life aspect." (8)
4.1.5 The role of the anaesthetist

The anaesthetist's role was to "represent the views of anesthesia" (5) in a generic way. Since there was no scope to assess the patient before the MDM his contribution was not a personal impression on a particular patient. The co-morbidities of patients being presented was the main contribution made. This was sometimes overlooked because the focus of discussions was around the patient's cancer. It was felt that surgeons were not the best people to comment about a patient's co-morbidity. It was suggested that some surgeons would use a patient's co-morbidity as an excuse for not performing a challenging operation by claiming the patient was too unfit to undergo major surgery. This would mean alternative non-surgical treatments would have to be considered. The anaesthetist's presence at the MDM was necessary as it was claimed that surgeons would hide behind the anaesthetic risk if

"the surgical challenge is something that they'd rather avoid. And rather than say that sometimes I get the impression that they use the patient's co-morbidity as an alternative excuse. And in that sense I can see that's where there's an area of inconsistency that perhaps needs pointing out". (5)

In this way the anaesthetist agreed with the label of "watchdog of the MDM".

4.1.6 The role of the radiologist

The radiologist's role in the MDM was to complete and present the radiological staging of the patient. It was this role that was considered by the clinicians as being the most useful aspect of the MDM – some even stated that it was the only real advantage of having an MDM. Although the scans could be assessed by the
clinicians themselves, it was important that they could discuss them with a
specialized radiologist at the meeting, as stated by one of the surgeons:

'The advantage of the MDM is to have a specialized radiologist go through the
scans with us…to obtain the alternative views.'(3)

Although education was not mentioned by the radiologist personally, all members
of the MDM found the radiological discussions to be the most educative part of
the meeting (see later, chapter 4.2.3.8)

4.2 Function and benefits of the MDM

There were a number of sub-themes identified under the function and benefits of
the MDM. These were completion of radiological investigations, patient benefits,
improved team working, Consultant reassurance, convincing patients, treatment
and equipment planning, data collection, information gathering and education.
These will be discussed separately.

4.2.1 Completion of radiological investigations

The MDM was where the patient’s radiological and pathological investigations
were discussed, and a decision made on the most appropriate treatment for that
patient. The MDM had ensured that the entire patient’s investigations were
complete before they underwent definitive treatment. This sometimes had not
occurred in the past and had lead to potentially disastrous situations where
patients had needed scans whilst already under a general anaesthetic awaiting
surgery, or worse still finding out they had incurable cancer as they were about to operate. This was explained very clearly by one surgeon:

The MDM 'allows new patients to make sure that all their investigations are complete and that they are viewed in totality so that errors and mistakes and best management is carried out. Sometimes you'd hear horror stories where a patient was being wheeled down for a chest CT whilst asleep because it hadn't been done. Or that the chest x-ray hadn't been looked at and they'd got disseminated disease.' (11)

Previously radiological imaging was only requested in specific cases as deemed necessary by the clinician in charge of the case at informal X-Ray meetings. This meant that there was no way to check if all the appropriate scanning had been done, or if they had been adequately reported. This system made it much harder for the radiologist to accurately report scans, as he was only able to view scans brought along to the meeting by the clinician. With the advent of the MDM this had significantly improved, as there was now more time to review all the necessary scans. As the radiologist commented:

'We used to run informal x-ray meetings. There was no guarantee with the old system that all of the images would be reviewed. The clinical teams would bring along cases that they wanted discussing but I never had any warning about it - I would just have to interpret the scans there and then.' The MDM has had 'a huge impact because I see the cases now at least 24 hours in advance.' (9)

Having a discussion about the scans at the MDM had improved the quality of reports produced by the radiologist. The radiologist now knew what the clinician requesting the scans would be specifically looking for. He was also able to produce detailed reports depicting staging classifications of the tumours, which
helped surgeons decide which surgical option to choose. This had helped the radiologist produce consistent reports that all were in agreement with, as stated:

“We have a standard agreement with our surgeons here in terms of staging approach, factors that are unfavourable for surgery are common knowledge amongst our group - there’s a standardization of evaluation. Its not that we’re always right or anything like that but it means that at least we’re consistent” (9)

4.2.2 Patient benefits

Although patients did not attend the MDM themselves, there were indirect benefits for those who knew they were going to be discussed at an MDM. This was mentioned by both the CNSs interviewed. Patients felt reassured that their treatment decision was being made by a group of Consultants, and that there would be other healthcare professionals present at the meeting not only doctors. This was best illustrated by the comments made by one of the nurses:

“They (patients) actually like the idea that their case is not just discussed by one Consultant, that they actually get a second and a third and a fourth opinion. So they actually feel quite comforted.” (1)

4.2.3 Improvements in team working

Although this is a sub-theme of the benefits of the MDM, there were many themes identified from improvements in team working at the MDM. These will therefore be discussed under separate headings.

4.2.3.1 Appreciation of each other's roles

Working together as a team had had many benefits that were acknowledged by all the subjects interviewed. The MDM had helped its members appreciate the
role of others in the patient’s management. It had improved the personal relationship between individual consultants, and had helped people understand some of the differences between the clinicians. This was best illustrated by one interviewee:

‘You get an understanding of everybody’s role so you appreciate every member of the MDM and what they actually put into the patient.’ (2)

4.2.3.2 Keeping up to date

Because of the open discussions at the MDM, clinicians were made to keep up to date with the latest research and offer their patients the most pragmatic treatment available. Consultants were no longer working in isolation. This was evidently not happening before the advent of the MDM when the treatment received by the patient depended on what the Consultant’s experience was. The importance of keeping up to date with latest medical advances was emphasized by one of the nurses:

‘You’re working more as a team rather than in isolation. We all have a duty of care to our patients and within that duty of care is to keep ourselves updated and be willing to retrain on different things.’ (1)

4.2.3.3 The most appropriate specialist

Because patients were being discussed within a team of specialists it was no longer the case that patients who were referred to a surgeon had surgery whilst those referred to an oncologist had chemo-radiotherapy. Now the most appropriate specialist treated the patient, rather than the specialist initially allocated to them. The MDM had made it easier for patients to get passed on to
the most appropriate member of the team who could treat them. This was also useful to keep waiting times down. The nurses felt that making sure the patient was treated by the right specialist was a major advantage of having an MDM, as illustrated by one:

"Rather than be precious about patients, the MDM actually ensures that when patients come through the MDM they actually have the treatment by the best person of the MDM for that person." (1)

4.2.3.4 Controlling the maverick

Another benefit of team working was to prevent the sole practitioner from working without the approval of other professionals. It had ensured that all practitioners adhered to best practice guidelines for cancer management. This was deemed to be a major failing in the past, with some surgeons suggesting that cancer patients were treated inappropriately and one describing the MDM as having powers to 'control the maverick' (10).

4.2.3.5 Reassurance for Consultants

Consultants derived great reassurance from making decisions as a team, particularly when unsure about a patient's management plan. This was especially useful for junior Consultants who could feel isolated when they first become appointed to the post. They felt reassured that their decisions would be supported by more experienced Consultants. This was illustrated by one of the Consultant surgeons:

The MDM is a 'great forum for newly appointed Consultants. However well trained you are you still don't know it all. The existence could be a very lonely,
lonely experience. It was very positive to realize that if I didn’t know what to do with a patient largely neither did anyone else. This gives you more confidence as an offshoot. That’s an empowering position because as a junior Consultant you can feel very lost regarding your ability to treat these patients and you realize that guys with 25 years experience also don’t know how to treat the same patients.’

(4)

4.2.3.6 Helping to convince patients

The MDM was useful when there was debate with the patient over their best treatment. If patients would argue with the Consultant over their treatment instead of offering them a second opinion they would state that the decision had been made with the backing of the MDM. This was especially true if the decision concerned not treating a patient because of recurrent disease or incurable cancer. Following the MDM’s decision was also seen as a help if there were any legal ramifications of the decisions made. This was summarized by one surgeon:

‘I think it’s easier to make difficult decisions for patients and then it’s easier with the backing of the MDT to go back and explain (that) to the patients.’ (12)

4.2.3.7 Data collection

Data collection has been easier with the MDM, especially in terms of audit and maintaining a head and neck cancer database. It was also seen as a “vehicle for centralization” (4) in that patients from the peripheral hospitals, whilst not necessarily being treated at the main centre are presented at the MDM so their details have been registered. It was acknowledged that the MDM facilitates recruitment of patients into clinical trials, and was useful in the development of protocols to plan patients’ treatment.
4.2.3.8 Education

All members of the MDM derived educational benefit from attending the meetings. Maxillofacial and ENT surgeons learnt more about each other’s discipline which is especially important since there was often a cross-over between the two specialties. All the subjects mentioned that they had derived great benefit from viewing the scans as they were being presented by the radiologist. This helped them visualize the tumours better, which in turn helped them appreciate the effect the disease had on a patient’s ability to speak and swallow.

4.2.3.9 Information gathering

It was important for the AHPs to attend the MDM to gather the relevant clinical information which they could translate to the patient. This was important for the nurses in particular. They felt that patients would ask them to explain the doctor’s decision to them, as they were more likely to understand the nurse’s explanation than the doctor’s. Because they attended the MDM the nurses knew the full treatment options available to the patient, as well as the extent of the tumour and likely prognosis. This means they are well equipped to explain all these things to the patients. This had been a marked improvement from before, when they would need to refer the patient back to the treating Consultant. This advantage was highlighted by one of the Consultant surgeons:

‘I think what’s important for the more peripheral people to the decision-making process is that they understand why those decisions are being made – they spend more time with the patients discussing why the decision was made. They might get asked what the alternatives are and having been to the MDM they
might be able to give a more informed opinion. In the past they might have said 'well that's something you'd have to ask the surgical team'. They are a more intrinsic part of the process of looking after the patient.' (12)

4.2.3.10 Treatment and equipment planning for AHPs

Before the MDM was introduced some of the AHPs would only find out about patients when were admitted onto the ward. This had made it very difficult for them to plan their treatment or order equipment. Now they attended the MDM they would know which patients were being admitted in advance, which gave them sufficient time to plan ahead. This was especially important for the dieticians who often would recommend patients had extra nutritional support before they started their treatment. Before, it was on a very random basis that patients were assessed nutritionally prior to treatment, and depended on the Consultant responsible for the patient. This had improved the team's attitude toward pre-treatment nutrition, as was highlighted by the dietician:

'The MDM has made the team more pro-active, especially with relation to having PEG insertion. Previously referrals would be made for nutritional support on an ad hoc basis, usually when patients were already on the ward. Now not only are they having PEG insertion earlier, they are also having pre-operative nutrition as well.' (6)

The physiotherapist often had to order specialized equipment for certain patients that would take two weeks to arrive. Before the MDM, there would be limited opportunity to do this. The physiotherapist would have to chase patients up, as well as Consultants and other AHPs to discuss the treatment options. Now he attended the MDM equipment could be ordered well in advance.
4.3 Disadvantages of and problems with the MDM

Despite all the advantages identified with the MDM there were also considerable problems with it. There were sub-themes identified which were loss of the nurse MDM, the workload on radiology and cost implications, the decision making process, non-contribution by the AHPs with reasons and time constraints.

4.3.1 Loss of the “nurse MDM”

AHPs used to run their own “nurse MDM” on a regular basis which had not taken place since the advent of the MDM. This would involve a ward meeting of the AHPs as well as social workers, district nurses and occupational therapists to plan the discharge of the patient home. Sometimes a Consultant would be present. Because of the MDM the AHPs had not been able to find the time to reintroduce this, and this was having an impact on the patient's care as illustrated by one of the nurses:

'I think complex discharges need to be planned and I think that is what we're missing out on... planning can be a little bit too rushed.' (1)

4.3.2 Workload on radiology and cost implications

The radiologist at the MDM had to report scans from peripheral hospitals which raised many issues. Although the scans would be reported on by a Consultant from that hospital, often the scanning was incomplete and further investigations would need to be completed. Also, all the scans would have to be reviewed by the radiologist at the MDM, even if another Consultant had already issued a report. This was due to incomplete staging rather than inaccuracies in the
reporting. Consultants who were seeing head and neck cancer cases infrequently would not be inclined to use a tumour staging classification. It was therefore necessary for the MDM radiologist to review and re-report all the scans.

This had lead to funding problems since the radiology department was not funded for taking on the extra peripheral hospital work. It was a great cause of concern as illustrated by the radiologist:

'We're only funded to investigate (our) patients. We're not a tertiary referral centre from the point of view of litigation. Patients should be 'investigated in their base centre, that should be completed and then we review the cases at the MDM. And that's not working so we're doing quite a lot of extra radiology here.' It's 'a completely new extra workload. So we're effectively a Consultant and a half, 2 Consultants down by virtue of the time consumption on MDMs (from the whole hospital).'

(9)

4.3.3 Decision making process

One of the key functions identified of the MDM was the ability to discuss the best possible treatment for the patient. It was seen by many as the best setting for which to decide the course of treatment the patient would eventually have, providing it was in accordance with the patient's wishes. Most clinicians followed the decisions made at the MDM, and if there was disagreement they would "try and persuade the MDM round" (4) or would change their practice accordingly.

However, this view was not universally shared. Some Consultants felt the MDM only issued recommendations, whereas the actual decision was made by the Consultant during their assessment of the patient. Some felt this was a major flaw in the way the MDM worked, as sometimes the MDM would insist on making
a decision on a patient's treatment that was often not possible from the
discussion. Others felt that there was no point in discussing a patient unless a
treatment plan was completed. The reason why a decision was sometimes hard
to make was that often the most appropriate decision was not to treat, which
many found hard to make. This was highlighted by one Consultant surgeon:

'The problem with the MDM is that the MDM wants to make a decision...often the
most appropriate decision is to do nothing...that's an option that's not often
discussed but is often the option the patient will take themselves.' (3)

Another reason for not reaching a decision at the MDM was because the
patient's co-morbidity was often underestimated by the way they were presented
at the meeting. This was recognized as being difficult to do in the context of a
meeting:

'The problem in an MDM is that a lot of the information of co-morbidity
performance status is very difficult to transmit accurately.' (10)

Therefore some Consultants would ignore the view of the MDM if it was not
considered appropriate by them after assessing the patient. These Consultants
also questioned whether they needed to discuss patients at the MDM at all.
They were of the view that the majority of the decisions were 'perfectly obvious
before they even got to the MDM' (10) and only a small minority of patients
actually needed to be discussed.

4.3.4 AHP non-contribution with reasons
A common issue mentioned by nearly all the MDM members was that of non-
contribution by AHPs. Some such as the physiotherapist and dietician would
contribute freely to the discussions at the MDM. The dietician admitted that contributing at the MDM was a ‘bit daunting at first’ (6). However over time, things had improved and Consultants would now invite her contribution.

Nurses and SLTs perceived they didn’t get their views across at the MDM often enough, even though what they had to say was important for others to hear. This was also noticed by the other members, especially the Consultant staff.

The priority of the MDM seemed to be to only discuss treatment plans for the patient, especially since time was often pressured. This was because people were conscious of having to attend the clinic after the MDM. One Consultant felt there were too many patients on the MDM list, so that only the medical issues were discussed:

‘Just because of the numbers of patients we’re discussing it’s swept aside to discuss more tumours rather than the holistic picture.’ (3)

Medical domination at the MDM made it difficult for AHPs to contribute, especially for the nurses. This was because nurses were “not involved so much in the decision-making” (1) as compared to the doctors. This meant that the issues they wanted to discuss were not mentioned, unless it was an exceptional circumstance, as one stated:

‘If I hear something that’s a burning issue that I think everybody needs to say then I will say something. Maybe we need to be a bit more vocal and say actually we’ve spoken to the patients.’ (1)
But there were other reasons why AHPs did not contribute and this was related to the atmosphere generated by mainly the medical staff present. There were frequently heated debates between the surgeons which discouraged nurses from contributing in case they ‘added fuel to the fire’ (1). One Consultant described it as being frightening for other members and that they would have to be a brave character to contribute. The reason for this hostile atmosphere was explained by one Consultant:

‘The MDM represents a group of aggressive high achievers put together in a room occasionally with polarized views...from different disciplines.’ (3)

This was recognized by the nurses themselves. They perceived their nature as being ‘hesitant’, so they were unlikely to want to contribute anyway. The nature of the MDMs was described as “political hotcakes” (2), with “sparring” (1) between the two sets of surgeons. They felt they had to read the situation before they would say anything.

Consultants would like AHPs to be encouraged to contribute more by altering the atmosphere generated at the MDM, especially by making it less confrontational. This was illustrated by one Consultant:

‘The dynamics of the meeting can make it difficult sometimes. And sometimes it works extremely well. But other times it can turn into quite a combative forum and I think we need to encourage the PAMs (professions allied to medicine) as well as trainee staff to have more say.’ (3)

Another way to encourage the participation of AHPs would be to encourage the discussion of quality of life issues. The nurses mentioned that one Consultant at
the MDM was keen on discussing these issues and would ask them their opinion on it occasionally. Not treating the patient was rarely discussed at the MDM, and this was again because of the attitude of the surgeons. Some did not want to be seen as taking the weaker option by not operating on a patient, making it confrontational at times, as illustrated by one of the Consultants:

The MDM is 'Gladiatorial...there's a very macho approach to it – 'I can operate on this, you know, I can do this, you should offer this to the patient.' So I think there's a degree of one-upmanship. To someone very junior it's very difficult to stand up in that sort of situation and actually say well you know is there an option here not to do anything at all, just to offer supportive care.' (3)

The Chairman of the meeting was one of the Consultant Maxillofacial surgeons. He was asked whether he felt that inviting the AHPs to contribute may be helpful. He said that he often took their non-contribution as an inference that they were in agreement. This may not always be the case but it was recognized that often there were differences of opinion and after a lot of discussion the best plan was usually made:

'I don't actually think that everybody's in agreement. I think that probably a lot of people don't agree but there comes a time when you say 'well we're going to go with that.' I think a lot of us sometimes feel 'mmm I don't necessarily agree' and there's often quite a lot of discussion. But we usually come up with a reasonable solution.' (12)

4.3.5 Time constraints

The MDM had problems with time. There was not enough time to discuss all aspects of the patient's care so the priority was to plan the patient's best treatment. The MDM was followed immediately by a MDT clinic, so if the
meeting overran time for which to see patients in the clinic was reduced. The MDM was considered to be too long despite not being able to fully discuss other patient issues, so extending the amount of time taken for the MDM was not an obvious solution to the problem.

### 4.4 The MDT clinic – offsetting the disadvantages of the MDM

The MDM had made little impact in some of the clinicians’ decision making and the main reason cited was not having enough information about the patient for which to make the decision. The most appropriate place to make the decision was considered by some to be in the joint clinic that took place after the MDM. This clinic had been in place well before the introduction of the MDM, and was considered more valuable than the MDM by some of the Consultants:

‘We’ve always had joint clinics and so all patients were discussed between an oncologist and a surgeon in the clinic with the patient there and looking at the scans. And I think that good decisions were made there and still are in that situation. A true joint clinic...is obviously equivalent to an MDM.’ (3)

It was important that AHPs attended and contributed at the joint clinic, and their attendance there was more relevant than attending the MDM. Attending the joint clinic was a substitute for the AHPs for not contributing at the MDM, as pointed out by one of the nurses:

‘It’s not so bad because when I go to clinic I’m involved in those decisions - my concerns... the treatment plan, the choices to them and then support after that. So it’s easier after the MDM.’ (1)
4.5 Improvements – the ideal MDM

Subjects were asked to volunteer any changes they thought would improve the MDM. Some felt the MDM was working well, with the only real improvements to do with allocating more time to it, especially a whole session (i.e. the whole morning) instead of sharing the session with the MDT clinic. This would help encourage social issues to be discussed and reduce the pressure on Consultants commitments. However some felt the time allocated with the MDM was sufficient, but the number of cases to be discussed should be reduced.

A way to save time could be to introduce protocols for straightforward cases. Some, if not most of the decisions could be rubber-stamped through to save time, an idea suggested by surgeons and the oncologist.

AHPs could meet as a separate group before the MDM, to discuss their issues together so they can get their views across at the MDM. This would represent a return to the previously mentioned ‘nurse MDM’. This was something that the SLT in particular would like to see happening, as stated:

We should be ‘liaising more with the AHPs because generally we work closely together anyway. We don’t meet as a group although I’ve always felt we should meet as a group. And I think that will give more of a pivotal access into the MDT as well.’ (7)

The MDM should be discussing more social issues, and AHPs should be encouraged to participate. The AHPs felt that a question inviting them to contribute would not be time consuming and may allow other issues to be
addressed. One nurse felt that the question should not be aimed directly at one AHP in particular as it may force them to say something for the sake of contributing.

Funding issues should also be resolved, both in terms of Consultant hours and facilities. The visual display system was described as being hopeless and grossly underfunded. As afore mentioned, lack of funding for radiologists to attend the MDM should be addressed.