Chapter 5 - Discussion

This final chapter will discuss the findings of the study in the context of the function of the head and neck cancer MDM in this centre and in the context of the aims and objectives outlined at the start of the dissertation. Discussion will continue on to the implications this study may have for head and neck cancer services in the UK. Limitations of the study will be addressed and further studies that should be undertaken will be suggested.

The objective of the study was to explore the workings of the MDM in relation to recommendations made by IOG (Department of Health, 2002). The document was based upon the opinions of a designated group of specialists representing the views of head and neck cancer providers in the UK. This study provides evidence of the MDM workings which was not previously available to this group. It is the first study of its kind to utilize qualitative research methods in order to explore the workings of such meetings.

The MDM works effectively in many ways which support the current evidence showing that multidisciplinary team working is beneficial for healthcare workers treating cancer patients. Staff benefits are education, networking, communication and consensus on the decision making process. Patients are also thought to benefit from knowing their cases are discussed at MDMs. These have been highlighted in previous studies and are confirmed by the findings of this study (Gabel, Hilton & Nathanson, 1997).
There are several problems with the MDM identified by this study. Issues of time and financial resources have been raised briefly by other studies and will be discussed further here. The effectiveness of the MDM has also been questioned by some of this study's subjects. The main discrepancy from the findings of this study from IOG is that of non-contribution from AHPs. IOG states that "all clinical members should play active parts in discussing treatment plans". The reasons for this were presented in the findings and will be discussed in this chapter.

Some clinicians have openly questioned the purpose of having MDMs, even going so far as to say they were more harmful (in terms of financial resources) than beneficial. This issue will also be specifically addressed.

5.1 The role of the dietician
As illustrated in the findings, dieticians have seen a marked improvement in the recognition of patients' nutritional requirements since the introduction of the MDM. They contribute and participate fully in the MDM and have seen its introduction to be of benefit. Evidence that pre-treatment nutrition is an important factor in cancer treatment was probably not widely known before the MDM. This had seemingly improved due to the contribution made by the dietician at the MDM. Having the input of the dietician has educated the other team members, despite taking a while to do so. In this respect they fulfill their role as depicted in
IOG, defined as educating other members and inputting into patients' management.

**5.2 The role of the physiotherapist**

Planning for physiotherapy equipment was a problem before the MDM was introduced. Now there is adequate time to order vital equipment because the physiotherapist attends the MDM. Physiotherapists are part of the extended member list in the Manual, so it was surprising that there is no funding available for them to attend. From the testimony of the physiotherapist in this study, a case could be made to fund the physiotherapist to attend the MDM. It would be interesting to find out if other physiotherapists nationwide are funded to attend their MDMs and if so perhaps enable this physiotherapist to obtain funding to attend this MDM.

**5.3 The role of the cancer nurse specialist**

It is apparent from this study that nurses do not contribute in MDM discussions, but their attendance is an important part of their job.

IOG describes the CNS as having an essential role within the MDM. It states that a CNS must be present at every MDM, and along with the other AHPs, should contribute freely within the discussions. Nurses are ever-present at the MDM and gain many benefits from it. These include understanding the patient's disease better by learning from the radiological presentations, and information
gathering about the patient's likely treatment. This is important from the point of view of translating this information back to the patient at the clinic following on from the MDM. Nurses are the best members of the team to do this, widely acknowledged in this study and others (Jenkins, Fallowfield & Poole, 2001). The MDM has helped considerably with this part of their role and is the main reason why they support it. They only very rarely contribute to the discussions however e.g. when there's a 'burning issue'. Although they felt the MDM was not the most appropriate forum to express their views, they expressed a desire of wanting to contribute more.

It appears that their contribution at the MDM is not encouraged by the medical staff. This may be because their contribution there is not wanted. As was stated by several Consultants, the MDM is not the forum for nurses and other AHPs to make their views known, despite what is recommended in IOG. The input of the nurses is not lost however, because their contribution is still made in the clinics following on from the MDM. It seems that nurses gain from attending the MDM, but the MDM itself does not benefit by their presence. This is similar to the SLT, who also does not contribute.

This is in contrast to other AHPs like the dietician and physiotherapist who have no hesitation in making their views known.
The difference between nurses and other AHPs in contributing at the MDM warrants discussion. The nurses found the MDM intimidating, especially when fierce arguments erupted between the medical staff. The dietician also found the MDM ‘daunting’ at first. But still the dietician would contribute, nurses would not. Having a frightening atmosphere obviously does not help, but is unlikely to be the sole reason for non-contribution. An additional reason may be the impact the introduction of the MDM had on the working pattern of these groups. The nurses’ main role at the MDM is to act as a patient representative, a role they find easier to fulfill outside the difficult setting of the MDM. They do not tend to become involved with treatment planning. This is in contrast with the dietician and physiotherapist. Prior to the introduction of the MDM they did not have any opportunity to contribute to the patients’ pre-treatment planning. By their own admission, they would only receive ad hoc referrals from individual consultants. Often referrals came too late to either order equipment or to adequately improve the patient’s nutritional status before their treatment started. They would often have to seek out patients when they were already on the ward. For them the MDM is their opportunity to contribute to the patient’s management in such a way that would be difficult to do outside the MDM. This is perhaps recognized by medical staff, who appear to automatically address these issues without needing to be prompted. Nurses and SLTs can afford to wait until the joint clinic or when the patient is on the ward to make their views known. This would seem the likely cause of the discrepancy between the two groups.
5.4 Suggestions to improve contribution

The majority of clinicians felt the nurses could not contribute to the medical discussions, but their input into other aspects of the patient would be welcome. This was confirmed by the nurses own opinion of the situation. Suggestions on how to encourage AHPs to contribute more will be discussed here.

The Chairman may have an important role to play in this. Instead of concentrating solely on medical issues, bringing in the AHPs at the end of the medical discussion could be attempted. This would ensure the priority of discussing the patients' treatment plan is upheld. It would also ensure that the important social issues are addressed, without necessarily impacting on the seemingly more important medical discussions. However, as was mentioned by one nurse during her interview, AHPs would not like to be formally asked in front of the team, in case they simply said something for the sake of contributing. The question should therefore be a generic one, addressed to the MDM in general.

Another method would be to alter the set up of the MDM. Nurses have found it difficult to contribute if they are at the back of the room making it hard for their voices to be heard. This could be offset by re-organizing the MDM into a "head table" and an audience. The table would have all the important members of the team or a representative from each healthcare group to allow the discussion to be held in a more civilized manner. This smaller group may encourage AHPs to contribute freely without feeling the need to be formally asked. The audience
would consist of the other team members, as well as students and trainees who
learn significantly from attending MDMs (Jefferies & Chan, 2004). Members of
the audience can be invited to participate at any point during the head table
discussion, or at the end of the discussion. This arrangement may not be to
some AHPs’ liking - they may still feel intimidated by sitting in front of an
audience and may still feel compelled into contributing for the sake of saying
something. However, having them sit in a position of apparent importance would
ensure that their views are taken seriously and give them the proper forum they
need to effectively contribute in the team.

5.5 Nurse MDM
One major disadvantage since the introduction of the MDM has been the loss of
the ‘nurse MDM’, a meeting of all the AHPs on the ward to discuss social issues
such as discharge planning. This was lost because of time pressures since the
MDM was introduced. These issues are clearly not discussed at the MDM, and
so patient care appears to have been affected. Its re-introduction would be of
benefit for both patients and staff. This should be in addition to the current MDM,
as it is important that AHPs continue to attend the MDM. A recommendation of
this study therefore is to make available an extra session for AHPs in order to re-
introduce the nurse MDM. This will have cost implications but is an alternative to
having extra time allocated at the MDM to discuss these issues.
5.6 Decision making process

IOG states that the decision making process should be done at the MDM, with the proviso that the patient has the final say on any decision made. It is unclear from this study whether the MDM is actually useful in helping clinicians make a decision on a patient's treatment. The value of some MDMs have previously been called into question (Kee, Owen & Leatham, 2004). The views of the clinicians were mixed with some disregarding the MDM's decision if considered inappropriate to them and others following the MDM's decision to the letter. Some suggest that following the decision of the MDM was a necessity, particularly in legal terms. Others refute this claim, stating that the MDM only gives management guidance and does not alter the fact that the doctor ultimately takes legal responsibility for the patient. It seems that clinicians who see the MDM as the place for decision making will usually agree with the MDM's decision on the patients' treatment plan. If there is some disagreement, they will either find a consensus or will follow the MDM recommendation. Some clinicians would ignore the view of the MDM completely if they did not agree with the decision.

The reasoning behind this is not clear from this study. It may be that those that have this view were the senior most surgeon and oncologist in the department, the other three surgeons who support the MDM are more junior. Junior Consultants admitted that it was reassuring to hear the opinions of seniors at the MDM, especially when clarifying the decisions they had made in isolation. It cannot be ascertained from this study if as they become more experienced their
need for this reassurance diminishes. If so, there may come a time when
discussions at the MDM will have little influence on the eventual decision they
take with their patients. However, it simply may be a matter of difference of
opinion; it would be interesting to extend this study to other centres to see if this
is a universal truth. It would also be interesting to repeat this study in a few
years' time to see if having more experience makes a difference in the way junior
Consultants make decisions. Although some Consultants do not feel the MDM
benefits their decision-making process at all, it is apparent from the study's
findings that the MDM plays an important role in controlling the maverick clinician
who previously could treat patients without the input of any other specialty. This
function of the MDM needs to continue, and so it remains necessary for all
Consultants to present their patients at the MDM, regardless of whether they
derive any benefit from it at all.

5.7 Co-morbidity
Do surgeons hide behind co-morbidity in order to avoid doing challenging
operations? According to the anaesthetist they do, but this was not mentioned by
any of the surgeons. Co-morbidity has been shown to be the major reason why
recommendations of the MDM are not followed (Blazeby et al., 2006). Although
this cannot be precisely confirmed by this study’s findings, it was acknowledged
that co-morbidity was a major factor in determining whether a patient could
undergo a particular treatment recommended by the MDM. It was also
acknowledged that accurately presenting a patient’s co-morbidity was difficult in
the setting of the MDM. As the anaesthetist would not assess the patient before
the MDM, and often neither would the surgeon it appears that discussion over
the co-morbidity of a particular patient is theoretical, and depends very much
upon the information presented at the MDM. It seems that the anaesthetist's role
was to ensure the co-morbidity was not over-emphasized at the MDM in order to
sway discussions away from surgery. Yet according to the surgeons it seems
that co-morbidities are often underestimated by the way patients are presented at
the MDM, and are usually worse when they are seen in the clinic. It seems that
the best solution to this problem would be to ensure patients are fully assessed
by an anaesthetist prior to the MDM, as it seems that a great deal of decision
making depends on this factor. Whether this would be logistically possible
remains to be seen and would obviously impact on anaesthetists' time and job
plans if they had to assess every cancer patient before the MDM.

An alternative to having patients assessed by anaesthetists before the MDM
could be to allow them to attend the MDM. The subject of patient participation
was raised during the study but did not seem like a feasible idea given the
number of people present at the meeting. There is evidence that patients and
staff benefit from having patients present at the meeting without increasing
anxiety levels (Choy et al., 2007). However as was apparent in that study, this
would add considerably to already limited time and financial resources. It is also
likely that many head and neck cancer patients (who are usually from the lower
socio-economic classes) would not attend the MDM, given that patients from the lower socio-economic classes were reluctant to attend the pilot study.

5.8 Time constraints

Lack of time was a common problem raised by the MDM members. Nearly all the members mentioned the impact an overrun MDM had on the following clinic—even reducing patient access to clinicians. As is apparent from the current literature, MDMs are infrequently given adequate time and resources to run properly (Macaskill et al., 2006). Although some members would like to have a whole morning dedicated to the MDM, this may not be feasible in terms of financial resources.

To the credit of this MDM is the fact that a dedicated session (albeit only half a session in most Consultant's job plans) is given in which the MDM takes place. It is also to its credit that it is not squeezed into a lunch or breakfast hour unlike some (Macaskill et al., 2005). As is known, the majority of head and neck MDMs in the UK discuss less than 20 patients per meeting (Bradley et al., 2005). This MDM often discusses 40 patients in one meeting, making it one of the busiest MDMs in the UK. Despite this, the time allocated and taken for each meeting is not longer than other MDMs nationwide. This may be an area for improvement—it is not possible to reduce the incidence of head and neck cancer in the region, but it may be beneficial to have two MDMs at separate times of the week in order to cope with the demands on the service. Given that AHPs cannot even find the
time to re-introduce their valuable nurse MDM, it is unlikely that this idea would be feasible.

An alternative would be to rubber-stamp straightforward cases, a concept suggested by several clinicians. Protocols could be established and agreed upon by the MDM and identified cases treated as per protocol. This was considered to be the most obvious way to drastically reduce the number of cases needing to be discussed, although a further study would be necessary to quantify the exact number and which cases would be suitable. There is evidence that this may be feasible. Acher et al's (2005) study from a urology MDM concluded that clinicians were able to select out cases that required discussion, and were able to successfully decide treatment plans based on the information presented at the MDM.

This proposal would not be without its problems though. An important function of the MDM as identified by this study was to ensure the sole practitioner was kept in check. This was even acknowledged by those who did not openly support it. It is vital for this reason alone that all cases are presented at the MDM without exception. Having established protocols could mean a return to the situation before the MDM – clinicians deciding the best treatment according to protocol without allowing a full discussion to take place. It may also discourage clinicians from disclosing patients to the MDM – to the detriment of audit, maintenance of a
database and recruitment into clinical trials. However, the issue of time management at the MDM clearly needs to be addressed.

A further study to investigate whether selecting cases to be discussed before the MDM would be worthwhile. Clinicians could decide on the management plan of each patient after being given the information that would be presented at the MDM. If clinicians were unsure as to the best management plan for that patient, the case should be identified. This decision would be compared with the final outcome decision as made by the MDM. If it could be proven that clinicians were able to correctly predict the outcome of the MDM, and identify difficult cases, it could provide the evidence needed to reduce the workload on the MDM.

5.9 Costs

It is known that treating head and neck cancer patients is expensive and only £49,000 is allocated to the running of an MDM (Bradley et al. 2005). Each Consultant is paid half a session to attend the MDM, which equates to approximately £4,000 per Consultant per year. There are also traveling costs to consider for Consultants based at different sites. On top of that are the AHP salaries, cost of employing a full time coordinator, administration costs, and cost of facilities. Therefore it is possible that the cost of the MDM is not being met by funds allocated by the Government. It is imperative that the MDM is cost-effective and as was mentioned by the oncologist the MDM may not be the most effective use of resources if there is little perceived gain from it. There is
evidence to suggest that MDMs can reduce costs (Friedman & Friedman, 1979) by ensuring all the relevant clinicians are together to discuss the patient at the same time. It also appears that before the MDM staff had to chase up different healthcare professionals in order to discuss patients. This would obviously take up time and resources. The best estimate cost of running an MDM and whether it is actually cost-effective is uncertain, and warrants further studies.

5.10 Costs and the Radiologist

Recognized benefits have become apparent for radiologists by attending the MDMs. It helps them refine their reports to suit the surgeons’ requirements, and enables quality assurance of imaging reported by others. All members of the MDM felt the radiological presentations were the most educative aspect of the MDM. However as has been suggested by a previous study, the workload implications associated with attending the MDM has not been properly addressed (Kane et al., 2007). Head and neck cancer is relatively uncommon, and most general radiologists would not report on many cases each year. Having the reporting radiologist attend the MDM was not practical. It was too much to expect general radiologists to abide by staging classifications used by the specialist radiologist. Discussing staging classifications is a major advantage of MDMs (Davies et al., 2006) as was acknowledged by the radiologist. However reporting foreign scans i.e. those from peripheral hospitals adds significantly to their workload, for which they are not allocated dedicated sessions for. The previous study calculated a 20% increase in radiology department workload to
cope with the demands of the collective MDMs at that hospital. Whilst the exact figure for this hospital cannot be accurately calculated from the findings of this study, it can be deduced that the burden of the MDM has not been adequately dealt with. Since the radiologist is pivotal to the MDM, adequate funding would be necessary to ensure the MDM continues to function.

5.11 Limitations of the study
Due to time constraints, it was not possible to interview all the members of the MDM. It would have been of value to have been able to interview other nurse specialists from peripheral hospitals who only attend sporadically when one of their patients is being presented. It would have been interesting to see if they would have contributed to the discussion, especially since it would be likely that they were the only ones present at the meeting who would have assessed the patient. It would have been interesting to find out if they found the meeting to be cost-effective considering the traveling necessary to attend the meeting. Perhaps they would have raised the subject of telemedicine. This is not currently used at this MDM, but has been used at other MDMs to reduce traveling costs (Davison et al., 2005). This may have been an important topic of discussion with peripheral staff members but unfortunately remains a limitation of this study.

The core members of the MDM not interviewed were the pathologists and the palliative care specialists, and this represents a major deficit in the study’s findings. From evidence in the literature it seems that the MDM affects the
welfare and workload of pathologists and radiologists in similar ways (Kane et al., 2007). One of the reasons for this similarity is that they regularly input into the patient’s management but only play a peripheral role in the overall care of the patient. They never have any patient contact. Therefore it would have been interesting to see if the pathologist shared some of the views of the radiologist. Had the MDM educated them in what the clinicians needed to know from the pathology reports? Had the MDM significantly impacted on their workload, without the proper resources being available? If they had accommodated the MDM into their workload could their method of doing so be translated to the radiologists?

The other core member of the MDM that was not interviewed was the palliative care specialist. The reason they were not approached was because they do not attend the head and neck MDMs. It would have been of value to interview them to explore the reasons of non-attendance; especially given a lot of debate at the MDM is around the issue of palliative treatments. One of the functions of the MDM defined was to make a decision on the patient at the meeting. This was considered to be a disadvantage by some who felt that often the most appropriate treatment for the patient was no treatment (palliation). Not having a palliative care specialist present makes this discussion harder to complete – if present, the views of palliative care may influence the final decision of the MDM on a significant number of patients.
Ward staff were not interviewed for the same reasons and this again would have been interesting to explore why they did not attend. Ward staff spend even longer with patients and carers than CNSs, and they may be able to input into the patient's management options. It may also be beneficial for them to attend so they are made aware of patients to be admitted, their treatment plans and prognosis.

5.12 Further studies

Whether this study’s findings are reliable would depend if they are representative of the rest of the UK. This study therefore should be extended to other centres around the UK to confirm whether the findings are reliable. Semi structured interviews could be easily developed around the initial interviews undertaken here and applied to other MDMs. It would give valuable insight into whether the problems encountered in this MDM are similar, and whether this MDM should be improved. It may show the opposite of course, that this MDM is running far better than most.

It is likely that the findings of this study would be reproducible at other MDMs, based on Bradley et al’s (2006) survey of MDMs in the UK. The only real difference between this MDM and others is the number of patients discussed - only 3 MDMs in the UK discussed more than 20 patients, this MDM sometimes discussed 40. This may be one of the reasons for the perceived lack of time to discuss other issues other than medical ones, and why AHPs do not contribute
enough. It would certainly be interesting to find out if AHPs contribute more when there are fewer patients to discuss.

The atmosphere generated at the MDM by the medical staff is not conducive to allow discussions by non-medics. This may due to the personalities of head and neck cancer surgeons, or a lack of team working skills. If due to individual personalities, there may not be very much that can be done to improve on it. If because of a lack of team working skills, the MDM may benefit from training in effective team working. It would be worth re-studying this MDM after such training to see what effect this may have had on the MDM atmosphere.

5.13 Conclusions

The head and neck cancer MDM in this centre has made many improvements to the working lives of its members. It is promotes education, communication, research, team building and appreciation and benefits patients. However there are many issues that have been raised by this study:

- CNSs do not contribute in discussions at the MDM but their attendance is vital in order for them to work effectively in the team.
- CNSs make their contribution in the joint clinic after the MDM.
- Social issues are not discussed at the MDM. They are not given the priority they deserve because the MDM is too busy with too many patients.

This centre should consider having two MDMs per week.
• The time allocated is inadequate – time is pressured because the clinic follows in the same morning time slot.

• Clinicians vary in their use of the MDMs – most decisions could be rubber stamped to save time.

• Most decisions are made in the joint clinic with the patient present.

• Some find reassurance in their decision making at the MDM, this is applicable to junior Consultants.

• Physiotherapists should be funded to attend the MDM.

• The radiologist workload is huge because of the MDM. They need to be properly staffed and remunerated because their role is probably most important both in terms of education and input into the decision making process.

• The atmosphere created by the doctors is not conducive to the participation of the non-doctors and needs to be addressed. This could be achieved by having an impartial chairman, or team building skills.

• The anaesthetist plays a role in ensuring surgeons do not hide behind patients' co-morbidity when deciding on surgical options.