




Facilitating High Quality Cancer Care: A Qualitative Study of Australian Chairpersons' Perspectives on Multidisciplinary Team Meetings

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Aim: Multidisciplinary team meetings (MDMs) are a critical element of quality care for people diagnosed with cancer. The MDM Chairperson plays a significant role in facilitating these meetings, which are often time-poor environments for clinical decision making. This study examines the perceptions of MDM Chairpersons including their role and the factors that determine the quality of a Chair, as well as the Chairperson's perception of the value of personally attending meetings.

Methods: This qualitative study used telephone interviews to explore the experiences of MDM Chairpersons from metropolitan and regional New South Wales, Australia. Using a state-wide register, 43 clinicians who chaired lung, genitourinary, gastrointestinal, and breast cancer meetings were approached to participate. Thematic data analysis was used to develop and organise themes.

Results: Themes from the 16 interviews identified the perceived need for an expert and efficient MDM Chairperson with emphasis on personal rather than technical skills. The remaining themes related to the benefits of meetings to ensure quality and consistency of care; improve inter-professional relationships; and provide communication with and reassurance for patients.

Conclusion: The role of the MDM Chairperson requires expert management and leadership skills to ensure meetings support quality patient-centred care. MDMs are perceived to provide multiple benefits to both clinicians and patients. Efforts to train Chairs and to maximise clinician and patient benefits may be warranted given the costly and time-consuming nature of MDMs.

Keywords: multidisciplinary care, oncology, quality outcomes, cancer, clinical leadership

Introduction

Multidisciplinary teams are defined as a group of health-care providers with differing areas of expertise who work together with the intent to form consensus or evidence-based clinical decisions.¹ Research demonstrates various improvements to patient outcomes when care is led by multidisciplinary teams,^{2–8} such as improved survival rates across cancer types, increased adherence to oral chemotherapy and pain medication, and improved patient satisfaction.^{2,3}

Multidisciplinary management is accepted internationally as being essential to high quality care^{9–15} and considered the optimal approach in delivering quality care for people diagnosed with cancer.¹⁶ Multidisciplinary team meetings (MDMs) provide clinicians with ongoing opportunities to discuss and manage the complexities of

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diagnosis, treatment and management of cancer.^{1,2} In Australia, the 2016 New South Wales (NSW) Cancer Plan encouraged health services to take a multidisciplinary care approach to enhance the provision of high quality, patient-centred care and reduce clinical variation. This was further echoed in the Victorian state government's guide to achieving best practice cancer care, arguing the benefits of multidisciplinary teams.¹⁷ Patients perceive there to be benefit in engaging in multidisciplinary care.¹⁸

MDMs are held at a regular time with the primary objective to discuss and agree on a treatment plan and confirm staging for each patient based on the best available information, with input from an array of specialities such as surgery, radiation oncology, medical oncology, and pathology under the guidance or leadership of a meeting Chair.^{2,7,19–21} In following this consensus format, MDMs are intended to encourage coordination, streamline care, and reduce variation.²⁰

It is recommended that MDMs result in a documented plan for each patient case that has been discussed, and those plans be subject to audit and review on a routine basis.²⁰ Thus, effective communication, thorough preparation and documentation are paramount to ensuring optimal care via MDMs.¹⁸ However, there is little information reported about how multidisciplinary teams achieve their desired ends^{21,22} and in particular, how the Chairperson perceives they facilitate this process. The MDM Chairperson likely plays a crucial role in navigating an open, inclusive discussion and is typically responsible for deciding the number and order of referred cases to be discussed.^{10,23}

Although previous research has provided insight into team perceptions of MDMs,^{16,24} there are no known qualitative studies that specifically report on the perception of MDM Chairpersons on how best to provide quality patient-centred care within this time-poor and multi-skilled environment. The views of Chairpersons may be vital to the ongoing success of the MDM model and how improvements can be best implemented in practice. This aim of this study is to address this research gap by examining Australian MDM Chairpersons' perceptions of: (i) the role of the Chairperson and factors that determine the quality of leadership and (ii) reasons or perceived value of MDM attendance for MDM Chairpersons including any perceived benefits or risks.

Methods

Design

A qualitative methodology was employed to develop a comprehensive understanding of the views of MDM

Chairpersons in Australia. Semi-structured telephone interviews were conducted in line with the consolidated criteria for reporting qualitative research (COREQ) guidelines.²⁵ The project was approved by Hunter New England and University of Newcastle Research Human Research Ethics Committees.

Study Setting and Participants

Participants were recruited from cancer services located in New South Wales, Australia. Clinicians across several tumour types were identified via a government state-based registry and sent personalised emails to complete an online expression of interest. Personal invitations were also distributed to MDM Chairpersons known to the research team. Members of the research team have participated in extensive research into MDM settings prior to this study. To be eligible to participate, individuals must have had at least one year of experience with referring patients with cancer to MDMs and have acted as an MDM Chairperson. Of the 43 contacted and eligible, 16 MDM Chairpersons chose to participate.

Data Collection

A semi-structured interview guide was developed based on a rapid literature review and feedback from two MDM Chairpersons who commented on a draft interview guide, before being pilot tested with 2 health professionals. The interview guide included ten open-ended questions focused on the above-mentioned aims (see [Supplementary File](#)). Verbal consent was obtained prior to the interviews and data collection. Each of the interviews took under 35 minutes to complete with notes made throughout. Participants were asked questions regarding reasons or perceived value of MDM attendance, referral practices, proportion of discussed cases, organisation structure, and chair and team quality. Telephone interviews were conducted and recorded by members of the study team (LF & CP) between March and October 2019. Verbatim transcripts were imported into the data management program, NVivo, to enable analysis of complex and various themes as data appeared saturated.²⁶

Analysis

Thematic categories were developed using immersion and thematic analysis as outlined by Braun and Clarke's six-step process.²⁷ First, the two coding team members (LF & KB) listened to audio recordings of the interview for immersion and clarity. All interviews were then double coded by the two coding team members by drawing out initial codes throughout the data and placing themes into

categories. Once established, the coding team members collaborated, compared and delivered coding results into tables for analysis. Disagreements were reflexively discussed, and the codes were refined accordingly. The researchers coded 2–5 interviews between meetings, reviewing and defining themes before producing the manuscript. Meetings to discuss themes, codes and results were noted with a diary kept of the ongoing process.²⁷

Results

Participants

A total of 43 MDM Chairpersons were invited to participate, 16 completed an expression of interest and subsequently completed an interview. The sample included male and female Chairpersons located in metropolitan and regional NSW. The MDM Chairpersons spanned gastrointestinal, colorectal, thoracic, lung and breast tumour groups and included medical oncologists, radiation oncologists, and thoracic physicians.

Qualitative Themes

During analysis phase, themes and sub-themes were developed relating to the perceived value of attending MDMs. The themes are summarised as: 1. An Expert and Efficient Chairperson is critical; 2. Ensuring Quality of Care; 3. Inter-professional Relationships; 4. Communication with and reassurance for the patient.

An Expert and Efficient Chairperson is Critical

Skilled Chairpersons were considered paramount to ensuring the smooth operation of meetings to attain maximum benefit in producing quality patient care. It is important to note that participants did not necessarily attribute these characteristics to themselves personally, but instead perceived these to be ideal characteristics. Several participants noted past experience or other MDMs that had not been efficient as a result of the Chairperson. Poor chairing was described in terms of lack of preparation resulting in poor time management; a lack of clarity on what occurred after the meeting; and instances where a clinician or Chair had dismissed a colleague's opinion.

Necessary traits to effectively chair an MDM were described as a strong leadership style which combined a variety of intellectual, managerial and emotional competencies (Table 1). Participants noted that it was essential

for the Chairperson to be open, collegial, have the respect of their colleagues and possess strong interpersonal skills.

The ability to control the meeting to ensure each person can discuss their patients was also considered paramount to achieving the full benefits of MDMs (Table 1). Participants indicated that meetings are able to get off track, and emphasised necessity for the Chairperson to control the flow of the meeting. The smooth and timely management of meetings was repeatedly stated by participants as it related to important meeting outcomes such as ensuring all necessary cases are discussed, maintaining order, and retaining collegiality. For the participants, meetings needed to be precise, timely and informative to ensure they reach the standard of patient benefit whilst keeping the attendees engaged and willing to participate.

Ensuring Quality of Care

Participants believed MDMs are key to ensuring that consistent care was provided to their patients. High quality care via the MDM model was perceived as the combined expertise of multiple disciplines being focused on the complex facets of diagnosis and treatment; inter-clinician accountability; and, achieving consistent approaches to care.

Combined Expertise

Participants perceived that the combined expertise present in an MDM was vital (Table 2). The combination of specialties, disciplines and subspecialties was considered an opportunity to reach consensus on a person's diagnosis and develop or modify a patient's treatment plan where input was required from multiple expert opinions. The Chairpersons acknowledged complementary expertise, specialties, experience, and perceptions as a notable benefit to patient care.

Consensus on Complex and Comprehensive Care

As shown in Table 3, the perceived value of treatment discussions across specialties was considered to be particularly important for cases where care was very complex. In-person meetings were considered to provide clearer communication between clinicians and specialties for complex cases. Participants noted that collective discussion of complex patients was necessary for identifying all potential issues when providing quality, comprehensive care.

Chairs were asked what occurred if a consensus was not achieved. For many, this was perceived to be a "grey" area with most stating that they simply documented it in their letter to the patients' GP or in the MDM recommendation letter. However, there were no guidelines on how to

Table 1 Quotations About the Theme: The Efficiency and Traits of an Ideal Multidisciplinary Team (MDT) Chairperson

Participant Number	Indicative Quotation
10	“You have to be diplomatic; you have to be able to quell a noisy crowd. You have to be across the cases, you have to really construe the narrative because it can go off on a tangent You have to get on with everybody; you have to subtly discipline a meeting. You have to know as much as everybody in the room about the case. You have to listen and ... delegate effectively. So, you cannot scribe, you cannot take the minutes, you cannot interpret results. ... You have to be the orchestra conductor.”
6	“Well, knowledgeable, some humility and a good listener ... A good Chair is someone who doesn't talk too much, and who lets others talk. Who invites opinions from those who don't speak up.”
2	“So, going around and asking the key people their opinions to make sure those that may be a bit afraid to speak up feel that their opinion is valued. And giving them the chance and making sure everybody else is quiet so they can be heard.”
7	“Ideally, it would be someone who the whole group certainly respects and who is also able to elate [sic] some discussion sometimes, because on paper it seems like everyone can follow the step-by-step rules of what the recommendations are, each group gives their opinion on what the management should be for their patient.”
8	“I think someone who has good, level communication skills, ... who has good relationships with all the different specialties, and somebody who is organised and has a broad knowledge of management of the conditions which they are discussing, not just in their own speciality.”
2	“The problems I've seen have been about time. So, often you've got an hour, there's a lot of patients. And it's very easy for discussion to go off track. And so I think trying to rein that back in and cut people off and bring them back to the point.”
10	“You've got to be conscious of time and you have to finish on time. That's so important because meetings that run over just drive everybody crazy.”

Table 2 Quotations About the Theme: Combined Expertise and Consensus

Participant Number	Indicative Quotation
4	“ ... It's the sharing of expertise between various subspecialists. It's the expertise that each person brings to the meeting.”
5	“The patients we say should be discussed would be stage two to three [tumour type] cancer because those are the ones who likely need multimodality treatment ... We have also got some general category patients who need help with diagnosis. In that way, we are discussing the best way to get a diagnosis if it's not straightforward.”
9	“There's a very obvious and clear benefit in planning patient care, and it's particularly relevant in our cancers where they need multi-modality treatment ... to have all of the relevant clinicians in the room and examining the investigations is really, extremely useful.”
3	“Well, I think the big factor is someone that's not too vocal in their opinions. Because I find the MDTs I have been at where we have had bad outcomes are where you get one or two vocal people and they can sway the whole room by their personality. I think a good chair takes into account all the opinions and opens the floor up. But at the same time, keeps the meeting moving along, so that's actually quite a skill, I think, to be able to do that.”

manage disagreement (see Table 3). One participant, however, noted that this was not an issue as they made sure they always had consensus in their meetings (see Table 3).

It was the general perception of the participants that a high proportion of recommendations from meetings were followed

by the treating team; most Chairs indicated that treatment recommendations are followed upwards of 80% of the time (see Table 3). However, given the potential for these recommendations to be driven by group think or “a few vocal participants”, the chairs noted that it was essential to elicit

Table 3 Quotations About the Theme: Consensus and Accountability on Consistent Care

Participant Number	Indicative Quotation
16	"Often it will involve chatting to three or four different people who you cannot get in the one place, and it's really difficult to get some kind of consensus, whereas for the complex cases, it's a really valuable venue for I guess discussing the controversies and coming to some kind of consensus position."
13	"I think that for complex patients, it's important that every clinician looking after that patient sings from the same song sheet, that there's no confusion."
5	"I think the [tumour type] MDT is crucial in determining a comprehensive treatment plan for [tumour type] cancer patients because ... many people are treated with multiple modalities of treatment ... our patients often have significant comorbidities which need to be accounted for in determining that management plan."
2	"I think it's also good to ensure that you do not just have one person doing their own thing unchecked. It's good that as a group we can make sure that the management is appropriate. ... When we review it at the meeting, we realise actually there's a small area where the margin's involved. And as a forum we are not happy to let this patient go without having more surgery."
6	"I think MDMs have restricted the diversity of treatment protocols that are used ... I think people come with preconceived notions, and sometimes their ideas are changed when they come to that meeting. And that's why we are there. So, we learn from each other. We change sometimes our fixed opinions."
1	"The important ingredient is collegiality, really, and developing a team that is prepared to advise by evidence-based medicine, where the evidence exist. If you get people who are wanting to push their own barrows, for example, radiation or chemotherapy or surgery, and it's not based on evidence, well, then, of course, it will not work well."
13	"if you go against what the MDT have recommended, you're seen as an outlier."
6	"I attend for various reasons. One, is the patient care, so gaining consensus around treatment of patients with various conditions."
7	"It will simply get documented in the MDT letter and in the MDT notes that consensus was unable to be reached. And that these are the options that were discussed and that will obviously get sent out to the GP and the referring doctor. The clinicians themselves, it's up to them whether they want to document that in the patient's electronic file."
16	"I do not have any hard and fast rules, but I think if the discussion is not progressing after three or four minutes, then I think that's the point where I would suggest, well, is there a consensus? No, there's not, so we are going to document it as such."
10	"I make a huge effort to get consensus around our recommendations in our meeting. So, I actually ... We have our database on screen and I actually make a point of saying these will be the recorded recommendations."
15	"It's followed virtually 100% locally, but some patients, I'm talking maybe 5% end up at other treatment centres, tertiary centres, and they will do something different to what we've recommended, yes."
2	"The majority do so we'd probably be looking at probably maybe 80% I would say you do end up following what was discussed. But then there'd be the other 20% where the patient may not agree with what the plan was or may not be fit enough for that plan."

opinions from the wider group. Chairs reported that patient preference was often the reason for treatment recommendations not being followed.

Accountability and Consistent Care

MDMs were also perceived to hold an important role in holding clinicians accountable to following best practice as discussed by the group (Table 3). Chairpersons believed that it was important to ensure that each member was providing care

in a consistent manner, and that attendance at MDMs resulted in clinicians developing a practice of seeking team review before making complex or multidisciplinary decisions. The sounding board of peers was perceived to be a quality assurance exercise and a method of ensuring consistent care, particularly where clinicians might hold opinions not based on current evidence or hold fixed opinions. There was also a sense that the group would have a lower tolerance for risk

Table 4 Quotations About the Theme: Relationships and Relationship Building

Participant Number	Indicative Quotation
14	"Yes, so I guess you get the best patient care, and it does help communicate with the rest of the team the treatment plan so we're all in agreement."
12	"and it's good for general communication, I think, between all the team members. I think that in the end, [meetings] results in better patient care."
7	"It also provides a good opportunity to have the face-to-face interactions with the surgeons who are often our referral base and it can facilitate communication with them. It's often easier to do face to face than playing phone tag or through email."
7	"it's also a good forum for ... updating best practice or changes in management. So, for example, I might not necessarily be completely up to speed with new changes in systemic therapy management or new drugs, but it may come out in a MDT discussion that there is this big update at a medical oncology conference and there's a shift in the treatment paradigm for this particular stage of cancer."

or ambiguity in treatment decisions and management (eg, surgical margins).

When asked their likeliness to follow group consensus, one noted that recommendation was "biblical" and that once reached, a clinician would be unlikely to deviate (Table 3). This demonstrates the way group consensus at meetings can ensure consistent care for this Chairperson.

Chairs acknowledged several areas or circumstances where MDMs struggle to provide consistent and comprehensive care, particularly for complex cases. One common circumstance was when referral information provided to the MDM was incomplete. In this circumstance, chairs either delayed the patient case to the next MDM (potentially wasting scarce time) or a tentative decision was made based on what information was available.

Inter-Professional Relationships

Regular meetings provide opportunity for the participants to engage and interact with their peers and improve communication (Table 4). Engaging face-to-face with others from various clinical settings and expertise was perceived to foster relationships across multiple disciplines. Face-to-face communication in the meeting was perceived to provide an opportunity specifically for developing interpersonal relations as opposed to telephone or electronic communication. Overall, communication and team interaction was seen to be a significant benefit of participating in MDMs.

Communication with and Reassurance for the Patient

Participants perceived patient reassurance to be a key benefit of MDM presentation. As shown in Table 5, many

commented on how MDM presentation was essentially a process to collate a "second opinion" for patients and communicate that treatment plans were developed based on expert group consensus. For some clinicians, this level of reassurance was helpful in building partnerships with patients.

While group consensus was seen as reassuring for the patient, communicating lack of consensus was perceived as difficult. For some participants, differing opinions on smaller treatment details were considered a non-issue that would not need to be reported to patients, thus ensuring patient confidence in treatment was maintained (Table 5). However, other participants perceived a potential risk in providing patients with a group consensus rather than each individual medical opinion (Table 5). This risk was rationalised by some as the MDM venue providing quick access to a second or third opinion, as opposed a patient independently seeking these additional opinions themselves.

Patient communication of MDM decisions also infers that clinicians had gained consent for patient presentation to the MDM. However, the Chairpersons acknowledged that the process for gaining consent was clinician-dependent with very few having a formalised consent process.

Discussion

This qualitative study indicates that effective MDM Chairpersons are perceived to require a comprehensive set of leadership and interpersonal skills to ensure an efficient decision-making process in MDMs. The benefits of skilled Chairpersons leading these meetings are

Table 5 Quotations About the Theme: Patient Communication

Participant Number	Indicative Quotation
11	"You give the patient a lot of reassurance when you say to them, a group of doctors have sat down and reviewed this. And then they in turn give me reassurance. So, I think it helps to develop really positive working relationships with the patient. And it can expedite things for patients. So, instead of them having to go sequentially to see different consultants to get opinions we can usually get a combined opinion at the time."
8	"I think they make a difference in the sense that patients take a lot of comfort in knowing that their case is being discussed in a forum with other specialists and so they know the decisions being made are not just from one individual."
6	"I think, the only other risk is the patient doesn't hear second and third opinions directly. They're getting a consensus view from a group of doctors, so they don't directly hear the discussed conversation, and the second and third opinions."
11	"I suppose there's that fine line between open disclosure and having the patient fully informed. And working to not break the patient's or medically impact the patients' confidence in their overall management. If it was a very minor issue and really of no clinical concern ... I probably would not discuss it. But if it was a major issue then I would have to discuss that. ... But being able to present the different opinions of different people to the patient can sometimes help to clarify things for them."
13	"I cannot see the point in wasting time [referring every patient] ... I do believe that we do overall harm patients by discussing those cases that for which there's no evidence that discussion benefits."
5	"No, we do not ... sometimes we actually discuss patients before we see them. If I see someone that I am going to discuss, I will tell them that they are going to be discussed. And as long as we have got enough information from either a discharge summary or referral letter and some imaging, normally we can discuss. And then we will tell them afterwards, by the way, we discussed your case at the MDT and this is what was recommended. But we do not have any formal process for consent."
6	"We have no document ... So, we have electronic case records, but we do not have formal consent. Sometimes I write in the notes for MDM, and I have mentioned it to the patient, but it's not formal consent"

perceived to ensue from consensus and consistency in care, improved inter-professional relationships and reassurance for patients.

Chairpersons Play a Crucial Role in Providing Care and Managing Meetings

Participants in this study indicated that communication, decision making and willingness to participate in the meetings are key to being efficient. Similar findings were reflected in a recent review.¹ Furthermore, our study also indicates that the Chairperson holds primary responsibility for ensuring that the meetings run efficiently. In contrast, a national survey from a cross-sectional study in the UK that aimed to understand MDMs functionality from the perception of the MDM coordinators indicated that some believed that meetings ran just as efficiently when the usual Chairperson was unable to attend.²⁸

The Chairpersons in our Australian study indicate that they believe strong leadership, communication and meeting control skills were key to chairing a meeting. The necessary leadership skills described by the study participants incorporated a variety of intellectual, managerial and

emotional competencies.^{29,30} While our participants emphasised these qualities, our novel findings emphasised that being respected for one's technical expertise - "You have to know as much as everybody in the room" - was also considered to be very important.

There is a need to address barriers within group dynamics of meetings, with the Chairperson able to play a large role in communication gaps.²⁴ The UK's National Care Action Team issued a report based on the survey responses from over 2000 MDM members in early 2009.²⁴ The report states that it is essential for the Chairperson to have proficient skills in listening and communication; interpersonal relations; managing disruptive personalities and conflict; negotiations; facilitating effective consensual clinical decision-making; and time management.^{16,24} Perceptions of an ideal Chair are made up of traits such as assertiveness, good communication and team work rather than technical expertise.³¹

An effective MDM Chairperson requires a comprehensive set of skills; some of which are not taught as part of traditional medical training. This indicates that there could be room to explore the potential benefits of providing clinicians with

leadership skills training specific to optimising MDMs. It may be challenging for an incoming or more junior clinicians to assume this position; MDM Chairpersons who are mentored internally in a service have more opportunity to develop relationships and demonstrate competence. Such comprehensive skills include effective time management during meetings. Australian data indicate that each patient receive 5–8 minutes discussion time in a typical MDM.²¹ A literature review within the UK identified patients usually receive less than 2 minutes.³² Both timeframes indicate substantial time pressure within MDMs. Due to these workloads, it is vital that MDM Chairs are able to efficiently manage time in the interests of both team members and patients.

MDMs and Attendance Play an Important Role in Providing Quality Care to Patients

MDM Chairpersons identified meetings as necessary to providing patient centred care, which is consistent with other recent studies.³³ The main benefits identified by Chairpersons were combined expertise, consensus on complex care, inter-clinician accountability and achieving consistency in care. The specialised expertise that individuals brought to the meeting was considered to be a valuable element of multidisciplinary care. Research has demonstrated that patient complexity should be considered when making treatment plans and providing care.³⁴ Our results emphasise MDM Chairpersons' beliefs that meetings were particularly useful in discussing more complicated cases and complex treatment options.

It is apparent that patient benefit is an integral component of a successful meeting for MDM Chairpersons, and it therefore may be beneficial to integrate patient-reported outcomes to optimise and assess the successes of MDMs. The inclusion of patient-reported outcomes, including psychosocial aspects of care, is gaining traction among health professionals; for example, an audit of Australian cancer services reported 59% of MDM participants believe psychosocial aspects and outcome measures should be better incorporated into meetings. Emerging information about the complex relationship between multidisciplinary care, patient perspectives and outcomes and how this relationship can drive quality improvements to policy and health-care outcome measurement will shape future research into MDM.³⁵

Improved Interprofessional Relationships

Our Chairpersons indicate that the MDMs were in themselves an important strategy for improving inter-professional

communication and relationships. A National Multidisciplinary Care Demonstration Project identified communication to be one of five principles of multidisciplinary care for Australian women with breast cancer.³⁶ A National Breast Cancer Centre report identified inefficient communication between MDM members to be a major barrier in providing quality multidisciplinary cancer care.³⁷ Both of these reports are now over a decade old suggesting that gaps in communication are a long-standing issue and actionable strategies to improve clinician communication skills must be prioritised in national cancer control policy and draw in effective implementation and quality improvement strategies. Lack of communication within a health team can lead to poor decision-making¹⁶ and therefore, the capabilities of Chairpersons should include that of fostering inter-professional relationships in the context of MDMs.

Reassurance for Patients

The Chairpersons identified that providing the outcomes of MDM discussions to patients facilitated communication and reassurance for patients, and was therefore a significant patient benefit of MDMs. However, it was noted that approach could pose a potential risk in that patients may only hear a consensus opinion rather than individual various opinions. The manner in which team members navigated this issue was varied and was at the discretion of the individual medical professional regarding how much information they shared.

MDMs hold a critical role in holding clinicians accountable to delivering consistent care based on the most recent evidence available. The meeting requires a culture receptive to group critique and where individuals can discuss new evidence, and ensure the benefits are passed on to the patient while supporting the patient to seek additional opinion where relevant or desired. Furthermore, the model discussed by most of the Chairs portrayed patients as a passive participant in the MDM process; few had a formalised consent process, patient preferences were sometimes at odds with the MDM decisions, and the amount of information provided back to the patient was at the discretion of the treating physician. As health services continue to strive for patient-centred care, there is potential for MDMs to examine how they can incorporate patient preferences and communication.

Limitations

This study has some limitations, including a sample size of 16 participants and the focus on Chairpersons may have

limited the breadth of experience represented in the data. A larger or more diverse sample may have uncovered unreported themes; however, our sample did include four speciality areas of lung, genitourinary, gastrointestinal, and breast cancers. While numbers of participants in qualitative studies vary, we did reach saturation of themes through the 16 interviews.³⁸ The findings should be further tested via quantitative studies with representative samples of MDM members and Chairs.

We acknowledge that non-Chair team members may have different perceptions of required traits to lead an MDM. We chose to purposively sample Chairpersons as they were expected to have both knowledge of the demands placed upon the role and the experience of leading MDMs. Many participants noted they had dual roles as both Chairperson and regular MDM participant (of a different tumour type) and drew upon these experiences. Participants noted their experience in attending ineffective meetings and had both positive and negative examples of other Chairpersons. Due to the design of questions, the tone of the interviews were from a positive perspective. We acknowledge that this may limit the understanding of the negative attributes of a Chairperson and the impact on meeting efficiency.

Conclusion

The role of MDM Chairperson requires a variety of interpersonal and technical skills which are essential to ensuring that meetings optimally support quality, patient-centred care. Through a unique insight into perceptions of Australian Chairpersons, it is evident that expert management and leadership skills of MDMs are paramount in facilitating quality patient-centred care by bringing consensus and consistency; and fostering inter-professional relationships.

Data Sharing Statement

Due to the nature of confidentiality for our interview participants, data are not available for this study.

Ethics Approval and Informed Consent

The project was approved by Hunter New England and University of Newcastle Research Human Research Ethics Committees. All research subjects gave verbally recorded informed consent to participate in the study prior to study commencement, and to have their anonymised responses published.

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Author Contributions

All authors listed made a significant contribution to the work reported. NR, CP, LF, NZ were responsible for conception, study design, execution, and interpretation. All authors (NR, CP, LF, NZ and KB) have substantially contributed to and revised the article and agreed on all versions of the article before submission, during revision, the final version accepted for publication, and any significant changes introduced at the proofing stage, including journal selection. All listed authors agree to take responsibility and be accountable for the contents of the article. LF and CP were responsible for data collection. KB, LF, CP and NR were responsible for initial drafts of the manuscript. NR, CP, LF, NZ and KB contributed to manuscript refinement and proofing. KB and LF were primarily responsible for data coding and initial analysis.

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Disclosure

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