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Speak up! Factors that influence involvement of nurses in oncological multidisciplinary team meetings

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Abstract
Purpose – Nurses are capable of acting as advocates for patients since they hold valuable knowledge on patient preferences and their psychosocial needs. Yet, in practice they tend to contribute little to multidisciplinary team meetings (MDTMs). This study analyses the factors that influence whether or not nurses will speak up and increase patient-centred decision-making in MDTMs.

Design/methodology/approach – A multiple case study with cross-case comparison of twelve tumour groups across two Belgian hospitals was conducted. Data collection involved fifty structured non-participant observations and 41 semi-structured interviews with participants from the twelve tumour groups.

Originality/value – This study yields factors that increase the opportunities for nurses to speak up in MDTMs to enhance patient-centred decision-making. The findings help in the design of future interventions concerning multidisciplinary teamwork, that address nurses’ contributions to augment patient-centred care.

Keywords Case study, Hospital, Multidisciplinary team meeting, Nurse involvement, Patient-centred decision-making, Speaking up

Paper type Research paper

The authors would like to thank Masters’ students from Ghent University, Belgium for their support in collecting the data. There were no external funding sources for this study.
Introduction
The role of multidisciplinary team meetings (MDTMs) in cancer care has increased in significance in recent decades (Winters et al., 2021). In these meetings multiple and complex medical and patient-related information is considered by a multi-professional team whose members contribute various perspectives (Rosell et al., 2022). By bringing experts from various specialties together, MDTMs thus facilitate a comprehensive and integrated approach to patient care (Soukup et al., 2018). The collaborative effort in MDTMs ensures that all aspects of a patient’s condition are considered, leading to well-informed treatment plans tailored to the individual’s unique needs. Although a patient-centred treatment plan requires taking into account the patients’ psychosocial aspects (e.g. personal circumstances, independence and psychopathology (Lamb et al., 2011a)) and treatment preferences in addition to medical arguments (Wallace, 2017; Rosell et al., 2022; Horlait et al., 2019), recent literature illustrates that these aspects are rarely discussed at MDTMs (Soukup et al., 2018; Horlait et al., 2019). To overcome this issue, several studies have explored the possibility of direct patient involvement. However, this revealed concerns about potential interference with objective case considerations, the patient’s ability to cope, potential impairments of the decision-making process, greater time requirements, the need to modify medical terminology and the risk of discussion among providers becoming constrained (Bohmeier et al., 2021; Ansmann et al., 2021). Considering these barriers to active patient involvement, healthcare professionals in MDTMs, who know the patient and their preferences, should advocate for them. Nevertheless, research has demonstrated that these advocates, who are often general practitioners, psychologists, or nurses, are not always present during MDTMs, and if they are, they do not always actively engage in “speaking up” during the meeting (Horlait et al., 2019; Wallace et al., 2019).

Various studies have identified reasons why individuals may refrain from speaking up, also called “voicing”, for example, fear of damaging relationships with colleagues and superiors (Bienefeld and Grote, 2012; Detert and Edmondson, 2011), reduced psychological safety regarding acceptance of one’s input (Nembhard and Edmondson, 2006), or lack of assertiveness (Weiss et al., 2014). Hierarchical barriers and fear of reprisal from higher status individuals emerge as the primary reasons for silence (Milliken et al., 2003).

So far, healthcare literature discusses the concept of speaking up mainly in relation to patient safety in the clinical context (Noort et al., 2019). Schwappach and Gehring (2014) correspondingly define the concept, also termed “safety voice”, as “assertive communication in clinical situations that require (immediate) action through questions or statements of opinion or information with appropriate persistence until there is a clear resolution” (p. 1). In other words, speaking up can be interpreted as a situation where healthcare professionals identify, or become aware of, risky or deficient actions by colleagues within healthcare teams, and they express their concerns with the aim of enhancing patient safety (Okuyama et al., 2014). Whether healthcare professionals speak up when necessary in healthcare teams depends on contextual and individual factors. Identifying these influencing factors for hospital-based healthcare professionals was the topic of interest in the systematic review of Okuyama et al. (2014). Those authors distinguished a number of factors, namely employee motivation, clinical context, general contextual factors (e.g. hospital policy, team relationships and the attitudes of leaders), factors relating to individual employees (including job satisfaction, responsibilities to patients, educational background, confidence, previous experience and communication skills), the perceived safety of speaking up and the perceived efficacy of speaking up.

While speaking up in relation to safety in a clinical context is of utmost importance, remarkably, speaking up in relation to improving patient-centred care seems to be less widely examined in literature (Wilkinson et al., 2020a). More specifically, incorporating the patient’s perspective is considered critical in providing treatment recommendations that are likely to be accepted and effectively implemented by patients (Soukup et al., 2018;
Gandamihardi et al., 2019; Rosell et al., 2022). Several studies have shown that a treatment plan is more likely not to be followed, or to have to be stopped early, if it is not tailored to the patient’s individual situation or preferences (Winters et al., 2021; Rosell et al., 2019).

As nurses have access to valuable input that can be important in decision-making in the MDTMs they are important advocates for patients (Wallace, 2017; Rosell et al., 2022). In spite of this unique role (Garon, 2012), research shows that particularly nurses are cautious to voice their concerns (Labrague and De los Santos, 2020; Rosell et al., 2019; Wallace et al., 2019; Soukup et al., 2018; Horlait et al., 2019). This has been explained with reference to a number of points. For example, the fact that the medical perspective tends to play the main role in decision-making, with most communication being between physicians, makes the ability of nurses to become involved in the decision-making process limited (Rowlands and Callen, 2013). Not speaking up can also be caused by the fact that nurses do not always regard themselves as having equal status or power in the MDTM team (Rosell et al., 2022). Furthermore, the literature suggests that nurses are sometimes reluctant to speak out of fear of others’ responses, or because they are concerned that they will appear incompetent (Okuyama et al., 2014). Another factor that may hold back speaking up is that nurses have often not yet met the patient by the time that these discussions in the MDTMs are held, which is typically early in the clinical process (Wallace et al., 2019). Finally, time and resource constraints were also reported (Alexandersson et al., 2018).

Our study aims to examine the extent to which nurses advocate for patients during MDTMs in cancer care as an enhancement of patient-centredness. We highlight the importance of voice in MDTMs, which comprise an indispensable platform for the delivery of integrated cancer care. Whilst previous research has highlighted the importance of nurses’ participation in MDTMs, our study goes further by investigating the factors that influence their level of involvement in voicing patient concerns.

A second contribution is that we explored a new function of speaking up, namely the enhancement of patient-centredness. By addressing the need for nurses to speak on behalf of patients, we highlight the crucial role of their voices in achieving improved patient-centred decision-making in, among others, a patient-tailored treatment plan.

Methodology

Description of the empirical setting and study design

This study focuses on the “multidisciplinary oncology consultation” or MOC. A MOC is a consultation between different healthcare providers whose purpose is to discuss cancer patient cases and to come up with a treatment plan and follow-up for each patient (Dubois et al., 2018; Van Belle, 2008). For reasons of convenience, MOCs are typically organized as a collective meeting with all the patients of a single tumour group, though in fact such meetings are legally specified as being with one individual patient at a time (Horlait et al., 2019).

To investigate the role of nurses and the ways in which they can (or cannot) raise their voice in MOCs, a qualitative multiple embedded case study design was used. According to Yin (2009) researchers can gain insight into complex contemporary phenomena through case study design. This design makes it is possible to study real-life situations with contextual conditions over which the investigator has little or no control (Verleye, 2019; Eisenhardt and Graebner, 2007; Yin, 2009). Case sampling for this study has been performed purposively, as a particular phenomenon is being studied and participants are considered “fit for purpose” (Verleye, 2019). The goal was to include cases that might provide insights into the specific situation being studied (here, the involvement of nurses in the MOC). Specifically, two hospitals in Flanders, Belgium were selected; one is a large university hospital (hospital A) with 1061 beds and the other is a large regional hospital (hospital B) on different sites with 1369 beds. In total, twelve MOCs were included, and their demographics can be found in Table 1.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Case no.</th>
<th>No. of interviews/observations</th>
<th>Avg. team size MOC</th>
<th>Team composition MOC</th>
<th>Freq. of meetings</th>
<th>Infrastructure</th>
<th>Time of meetings</th>
<th>Duration</th>
<th>Avg. nr of patients discussed</th>
<th>Meeting structure</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1. Digestive oncology</td>
<td>2</td>
<td>18</td>
<td>Radiologists, Radiotherapist, Pathologist, Nuclear specialist, Medical oncologists, Data analyst, cancer registration, Oncological Nurse-consultant, Gastroenterologists, Surgeons, Resident doctors</td>
<td>Weekly</td>
<td>Large U-shaped table with twenty seats, two screens for images, one computer, two microphones</td>
<td>Tuesday 12 p.m.</td>
<td>1 h 15 min</td>
<td>22</td>
<td>Classify cases according to organ pathology</td>
<td>Two gastroenterologists, Rotating leadership</td>
</tr>
<tr>
<td>A</td>
<td>2. Uro-oncology</td>
<td>3</td>
<td>19</td>
<td>Radiologist, Radiotherapist, Pathologist, Nuclear specialist, Medical oncologist, Data analyst, cancer registration, Oncological nurse-consultant, Medical intern, Resident doctors</td>
<td>Weekly</td>
<td>Large U-shaped table with twenty seats, two screens for images, one computer, two microphones</td>
<td>Wednesday 12:30 p.m.</td>
<td>1 h</td>
<td>19</td>
<td>Medical oncologist decides case structure</td>
<td>Medical intern introduces cases</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Case no.</th>
<th>No. of interviews/observations</th>
<th>Avg. team size MOC</th>
<th>Team composition MOC</th>
<th>Freq. of meetings</th>
<th>Time of meetings</th>
<th>Avg. nr of patients discussed</th>
<th>Infrastructure</th>
<th>Duration</th>
<th>Meeting structure</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>3. Gynaecology</td>
<td>2 3</td>
<td>14</td>
<td>Radiologist, Radiotherapist, Pathologist, Nuclear specialist, Medical oncologist, Data analyst cancer registration, Oncological nurse-consultant, Medical Interns, Resident doctors</td>
<td>Weekly</td>
<td>Large U-shaped table with twenty seats, two screens for images, one computer, two microphones</td>
<td>Thursday 12:30 p.m.</td>
<td>1 h</td>
<td>24</td>
<td>Treating specialist introduces cases Discussion order: breast tumours pre-operative and post-operative, metastases</td>
<td>Medical oncologist</td>
</tr>
<tr>
<td>A</td>
<td>4. Pneumology</td>
<td>3 3</td>
<td>14</td>
<td>Radiologist, Radiotherapist, Pathologist, Nuclear specialist, Medical oncologist, Data analyst cancer registration, Oncological nurse-consultant, Medical interns, Resident doctors</td>
<td>Weekly</td>
<td>Large U-shaped table with twenty seats, two screens for images, one computer, two microphones</td>
<td>Friday 12 p.m.</td>
<td>45 min</td>
<td>7</td>
<td>Cases from hospitals that dial in introduced first Leader decides upon case structure</td>
<td>Pneumonologists</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Hospital Case no.</th>
<th>No. of interviews/observations</th>
<th>Avg. team size MOC</th>
<th>Team composition MOC</th>
<th>Freq. of meetings</th>
<th>Infrastructure</th>
<th>Time of meetings</th>
<th>Duration</th>
<th>Avg. nr of patients discussed</th>
<th>Meeting structure</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Bone- and soft tissue oncology</td>
<td>4</td>
<td>13</td>
<td>Orthopaedic surgeons Radiologists Medical oncologists Pathologist Radiotherapist Paediatric oncologist Data analyst cancer registration Oncological nurse specialist Medical interns Resident doctors</td>
<td>Weekly</td>
<td>Large U-shaped table with eighteen seats, one screen, one computer</td>
<td>Friday 1 p.m. Participants arrive later due to consultations</td>
<td>2 h</td>
<td>29</td>
<td>Leader introduces cases Paediatric cases first</td>
<td>Orthopaedic surgeon</td>
</tr>
<tr>
<td>6. Endocrine oncology</td>
<td>3</td>
<td>13</td>
<td>Endocrinologists Head and neck surgeons Radiotherapist Data analyst cancer registration Resident doctors</td>
<td>Weekly</td>
<td>U-shaped table with twelve seats, one screen</td>
<td>Thursday 12:30 p.m.</td>
<td>30 min</td>
<td>5</td>
<td>Specialised MOC, sometimes foreign cases</td>
<td>Endocrinologist</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Hospital Case no.</th>
<th>No. of interviews/observations</th>
<th>Avg. team size</th>
<th>MOC</th>
<th>Team composition</th>
<th>MOC</th>
<th>Freq. of meetings</th>
<th>Infrastructure</th>
<th>Time of meetings</th>
<th>Duration</th>
<th>Avg. nr of patients discussed</th>
<th>Meeting structure</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Head and neck oncology</td>
<td>5</td>
<td>14</td>
<td></td>
<td>Oncologists, Radiologists, Head and neck surgeons, Radiotherapists, Data analyst cancer registration, Psychologist, Dietician, Oncological nurse consultant, Resident doctors</td>
<td></td>
<td>Weekly</td>
<td>U-shaped table, two screens, one computer</td>
<td>Friday 9 a.m.</td>
<td>1 h 30 min</td>
<td>5</td>
<td>No specific structure</td>
<td>Oncologist</td>
</tr>
<tr>
<td>8. Liver oncology</td>
<td>4</td>
<td>23</td>
<td></td>
<td>Oncologists, Radiologists, Radiotherapists, Data analyst cancer registration, Psychologist, Transplant coordinator, Resident doctors, Oncological nurse (rarely)</td>
<td></td>
<td>Weekly</td>
<td>U-shaped table, two computers</td>
<td>12:30 p.m.</td>
<td>1 h 30 min</td>
<td>11</td>
<td>No specific structure</td>
<td>Oncologist</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Case no.</th>
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<th>Team composition MOC</th>
<th>Freq. of meetings</th>
<th>Infrastructure</th>
<th>Time of meetings</th>
<th>Avg. nr of patients discussed</th>
<th>Meeting structure</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Digestive oncology</td>
<td></td>
<td>5</td>
<td>6</td>
<td>Hepatologist, Gastroenterologist, Radiotherapist, Anatomical pathologist, Radiologist, Medical oncologist, Surgeons, Oncologist, Nurse consultants</td>
<td>Weekly</td>
<td>Round table, one screen, one computer</td>
<td>Thursday 12:30 p.m.</td>
<td>22</td>
<td>Post-operative cases from other hospitals discussed first</td>
<td>Oncological Gastroenterologist</td>
</tr>
<tr>
<td>10. Neuro-oncology</td>
<td></td>
<td>4</td>
<td>4</td>
<td>Neurosurgeon, Anatomical pathologists, Radiologists, Nuclear specialist, Radiotherapists, Data manager, Nurse consultants</td>
<td>Weekly (sometimes cancelled due to lack of participants)</td>
<td>Round table, one screen, one computer</td>
<td>Friday 4 p.m. 1 h and 30 min</td>
<td>10</td>
<td>No specific structure</td>
<td>Oncological Neurosurgeon</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Hospital Case no.</th>
<th>No. of interviews/observations</th>
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<th>Team composition MOC</th>
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<th>Avg. nr of patients discussed</th>
<th>Meeting structure</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Pelvic oncology</td>
<td>3</td>
<td>16</td>
<td>Oncological gynaecologists Medical oncologists Anatomical pathologists Radiotherapists Radiologists Nuclear specialists Nurse consultant Head nurse</td>
<td>Weekly</td>
<td>U-shaped table, three screens, one computer</td>
<td>Monday 4 p.m.</td>
<td>1 h</td>
<td>8</td>
<td>No specific structure</td>
<td>Oncologist</td>
</tr>
<tr>
<td>12. Thoracic oncology</td>
<td>3</td>
<td>21</td>
<td>Oncologists Pneumologists Thorax surgeons Radiologists Radiotherapists Anatomical pathologists Nuclear specialists Nurse consultants</td>
<td>Weekly</td>
<td>U-shaped table with ten seats, two screens</td>
<td>Wednesday 4:30 p.m.</td>
<td>1 h 30 min</td>
<td>3</td>
<td>No specific structure</td>
<td>No leader</td>
</tr>
</tbody>
</table>

**Source(s):** Authors' work
The cases selected for this study relate to several MOCs, as they are legally bound to a similar working structure, although they differ by medical discipline (see Table 1). MOCs must be chaired by a medical coordinator with participation of at least four different medical specialists belonging to hospital staff and one extra-mural participant. Non-physician oncology staff members (such as psychologists, nurses and social workers) are not legally bound to participate (Horlait et al., 2019). The degree of nurse involvement differs by case and by hospital, making these a good fit for comparison.

Data collection
Data collection involved fifty structured non-participant observations throughout the twelve MOCs and 41 semi-structured interviews with participants of the different tumour groups (see Table 1).

The context for the structured observational studies was the participants’ natural environment, and involved collecting data describing the behaviours and events we wished to observe (Cohen et al., 2017). Our structured observations were performed with a predesigned tool that described eighteen observable aspects of an effective MDTM namely, the Multidisciplinary Team-Observational Assessment Rating Scale (MDT-OARS) (Taylor et al., 2012). An observer used this tool and made additional field notes to document necessary contextual information. In this way, we gained insight into communication patterns, the interactions between the different participants of the MOC, and their behaviour.

For the semi-structured interviews, the Characteristics of an Effective Multidisciplinary Team criteria were used (NCAT, 2010). The resulting interview questions covered characteristics such as teamworking and culture, patient-centred decision-making and meeting organisation and logistics, all of which are important to the effective functioning of MDTMs. The questionnaire that guided the semi-structured interviews can be found in Appendix. Some examples of questions are: “What exactly is expected of you as part of the MOC?” “Who can represent the patient’s wishes and vision in the MOC?” “What are the competences of a good MOC leader?” The interviews aimed to give a deeper understanding of the observed dynamics, atmosphere and decisions-making processes in the MOCs.

Table 1 contains an overview of the number of observations and interviews per MOC. We relied on the interview transcripts and the notes taken during observation to serve as the primary data source for analysis.

Data analysis
Our analysis began with the within-case analysis and only then proceeded to the cross-case analysis, in line with the recommendations of qualitative data analysis (Eisenhardt and Graebner, 2007; Yin, 2009); the analysis also heeded Verleye’s (2019) recommendations on the coding of qualitative data. The software employed was NVivo version 11. Two researchers, who were also involved in the data collection, started by familiarizing themselves with the data. Then the coding was performed by one of these researchers, who continuously discussed the resulting insights with the other researcher. Their output was shared across many meetings with the rest of the research team (Verleye, 2019). Following, the two researchers included the comments/interpretations and accepted optimizations to the coding suggested by the research team. This enabled detailed insights without jeopardizing the credibility and trustworthiness of the findings (Langley and Klag, 2019).

The categories and subcategories were derived from Okuyama’s factors for speaking up (2014, p. 5) and the characteristics of optimal functioning MOCs (Horlait et al., 2021); these were incorporated into the coding process while also leaving room for open codes to emerge as well (Table 2). Through this coding, at once deductive and inductive, greater insight was gained into the mechanisms that lay behind the speaking up behaviour of nurses in the
specific setting of MOCs. Once coding of all individual cases was complete, a cross-case analysis was performed by exploring similarities and differences between the cases.

**Ethical considerations**
This study was approved by the Ethical Committee of a Flemish University Hospital (reference no. 2019/0101) and the participating hospitals. Prior to the commencement of the study, all participants were informed of the study’s purpose and the nature of their involvement. Written consent of all participants (for observations and interviews) was obtained at the start of data collection.

A data management plan was developed and approved through DMPonline.be to describe data handling, data storage and data protection. All data used for the reporting and analysis were pseudonymized and stored in a secure location accessible only to the researchers.

**Findings**
An overview of the cases, annex tumour groups, can be found in Table 1 showing that these cases differ in tumour type, team size, meeting duration, leadership style and average number of patient case discussions. The interviewees made it clear that little attention is paid to psychosocial factors during MOCs. “I think that there’s too little attention paid to psychosocial factors.” (nurse consultant 2, case 2). The nurses in case 9 felt that there was not much room during the MOC to provide their input. Also during our observations it was noticed that psychosocial factors were rarely discussed.

In three of the twelve tumour groups (case 5, 7 and 11) nurses actively contributed to discussions. In the other seven groups, nurses were present but did not actively participate in the discussion (case 1, 2, 3, 4, 9, 10, 12), merely taking on a mainly observatory role, while making notes or acting as administrative support for the meetings. In one case, nurses did not attend the MOC at all (case 6), and in another case the nurse could only occasionally be present (case 8), due to time constraints.

The factors affecting nursing in the different cases can be divided into three categories with different subcategories (See Table 2). The first category is labelled “factors at hospital level” which includes hospital policy, time constraints and support. The second category is “factors at team level” with subcategories teamwork, team relationships, team size, leadership and professional roles. Finally, category three comprises “factors at patient case level.”
Category one: factors at hospital level

Within this category, subfactors that play a role in the speaking up behaviour of nurses include hospital policies, (i.e. alternative meetings as communication channels), and time constraints besides the availability of supporting tools.

Hospital policy. When apart from the MOC’s other meetings are in place, where nurses can discuss patient cases with physicians (e.g. ward meetings), the MOC meeting is mainly used to draw up the treatment plan. In ward meetings, however, nurses tend to speak up more as here not solely the treatment plan is addressed, but also other important elements, such as psychosocial factors. Similarly, sometimes nurses discuss cases with the physician ahead of the MOC meetings. In turn, this has an effect on the contribution of nurses in the MOC meetings.

The nurses in case 9 provide information to the treating physician before the MOC meeting. “At the MOC this is quite difficult, I don’t have the feeling that nurse consultants have a lot of input, maybe also because there simply isn’t enough time. But we do provide psychosocial information to the treating physician before the MOC takes place.” (nurse consultant, case 9).

The nurses in case 1 takes information along to the multidisciplinary ward meeting, which takes place after the MOC. “Next to the MOC, there is the multidisciplinary ward meeting, in which psychosocial factors are discussed in more depth. The MOC is about determining the direction of treatment with only the relevant psychosocial factors for that plan.” (nurse consultant, case 1). The information resulting from the MOC can guide further planning at the wards. “The point of my presence is to know which patients are being discussed, how many new cases and how many progressive cases. This is also important for our planning.” (nurse consultant 1, case 1).

The pathologist in case 2 also confirmed that nurses are present at the MOC to transfer information back to the rest of team: “The presence of the nurses is important, because they take information, that was discussed at the MOC, back to the team.” (pathologist, case 2).

The information provided during the MOC can guide further planning at the wards. “The point of my presence is to know which patients are being discussed, how many new cases and how many progressive cases. This is also important for our planning.” (nurse consultant 1, case 1).

Time constraints. As demonstrated in Table 1, the average number of patient cases per MOC is high. For example, case 2 and case 3 on average discuss 19 and 24 patients per hour, respectively.

“I don’t have the feeling that nurse consultants have a lot of input, maybe also because there simply isn’t enough time.” (nurse consultant, case 9).

In addition to time constraints in the MOC meetings themselves, not every caregiver has time to attend the MOC either. In case 8, the onco-coach was rarely present due to time constraints, sometimes arriving later or leaving meetings early. The role of the onco-coach (as well as of the psychologist) is to provide input on cases where a cancer patient needs transplants. However, they can only rarely be present at the MOCs, despite the indispensable need for their input. “The onco-coach and psychologist are involved in the discussion of mostly transplant patients. However, they rarely have time to be present.” (medical oncologist, case 8).

In case 6, the nurses never received an invitation to the MOC meeting, as their presence was not seen as necessary. “They never received an invitation. But now as we speak, there might be a new opening into the MOC and there is someone who sees the need for them to join and has a positive attitude towards it.” (MOC chair, case 6).

ICT support. Access to ICT support tools, such as eHealth platforms, is crucial for nurses if they are to contribute to the MOCs. In case 10, the nurses were hindered by not having access to the online collaborative care platform (CoZo), which allows patient files to be shared across different healthcare providers. The files shared on this platform hold essential information for nurses, however, access is legally limited. Nurses having unlimited access to this platform would improve communication with the treating physician.
At one point during an observation, the nurses indicated that not having access to the CoZo platform has slowed down their work and prevented them from preparing properly for the MOC (case 10).

Administrative support. Under Belgian law the administrative support role is taken by data managers (see Table 1). However, in case 6, the MOC chair highlighted a need for an additional team member for administrative support at the MOCs, as the physicians did not have sufficient time to coordinate or prepare the MOC discussion. “We need a person who can support the MOC on an administrative level. . . . However, we don’t discuss enough patients to receive reimbursement for this position” (MOC chair, case 6).

Category two: factors at team level
In the second category, subfactors team relationships, team size, leadership and professional roles affected the speaking up behaviour of nurses.

Team relationships. The manner in which teams collaborate affected the speaking up behaviour of nurses. Trusting your team members when working together in the MOCs is an aspect that the oncologist of case 5 considered very important. “You need to trust everyone’s expertise. When someone makes a suggestion, you have to trust that that is correct.” (oncologist, case 5).

In case 9, hierarchical structures within the team, prevented nurses from contributing to the discussions. “I think that sometimes hierarchical structures do play a role. We know we can always call the physicians when needed, but for some patients I do have the feeling I would like to contribute more during the MOC.” (nurse consultant, case 9).

In case 12, the relationships with the other MOC team members depend on which nurse attends the meeting. “It depends on the nurse who is attending the meeting. Some nurses have more contact with the team than others.” (oncologist, case 12).

Team size. In cases 8 and 9, we observed that when the MOC team is relatively large (more than twenty members), it may take more time before everyone has entered the meeting room and has their spot. During the meeting, several parallel discussions can occur at once in the room, resulting in unclear conclusions for a case. Furthermore, nurses were more likely to talk with each other in such instances, rather than with the representative of other disciplines.

In cases 10 and 6, the meeting usually starts on time because of the smaller number of participants (between ten and thirteen participants). However, in case 10 the meeting is sometimes cancelled because of a low number of participants.

Leadership. Having a distinct MOC leader who gives direction to the discussions, leaves space for additional input and clearly summarizes the conclusions, is necessary for a MOC to function properly and to ensure that all disciplines contribute to the discussions when needed.

In case 7, the team leader believed that nurses receive the space they need to contribute to the discussion. “If there is really important information that was not shared during the case introduction, then the nurse consultant will say so. She will always intervene when something is not clear or complete”. (MOC leader, case 7). Indeed, our observations revealed that nurses actively contributed to the discussions with information that was usually not shared during the case introduction and the team leader asked for and welcomed these contributions.

In case 2, several interviewees mentioned the absence of an appointed MOC chair who keeps track of time and ensures that all disciplines contribute to the discussions. As was noticed in the observations the leader did not steer the discussion and the final conclusion was often unclear, leaving some team members confused.

There is no MOC chair who leads the discussions and keeps an eye on the timing, which I personally think is crucial to the functioning of the MOC. (nurse consultant 1, case 2).

The MOC needs a good leader to guide the discussion. (nurse consultant 2, case 2).
Case 5 also lacked a distinct MOC leader, which frustrated the attending nurse, as most cases were introduced by the various treating physicians and there did not seem to be an appointed chair to lead the discussion.

There is no true MOC chair. It's not clear to me who holds this title at the moment. (nurse, case 5).

**Professional roles.** Different roles can be assigned to the nurse in MOCs. First, a relatively passive role can be allocated. Two of the interviewed nurse consultants in case 1 indicated that they did not view it as their task to contribute to the meeting, since the MOC is intended to decide on the treatment plan, based on medical information alone. These nurses perceived their role as passive and mainly to collect relevant information on cases in which their patients are discussed. In case 1, the nurses sit on the outer corner of the U-shaped tables with a laptop to take notes, confirming their passive position in the MOC. In case 2, the nurses also did not view it as their job to contribute to discussions, as the MOC was only for absorbing information.

The MOC is a medical meeting, which is mostly about surgical matters. . . I'm a nurse consultant, my job is not to contribute to discussions but only to absorb the information that is discussed. (nurse consultant 2, case 2).

This passive role may also be perceived by physicians that provide psycho-social information themselves and thereby recognize a supportive administrative role for nurses. For example, in case 4, the interviewee indicates that during the meeting the treating physician or general practitioner is responsible for providing both clinical and psychosocial information, while nurses are responsible for follow up with the patient. One interviewee explains: “The responsibility for the patients lies with the treating physician and also the general practitioner. The nurse is mainly there to collect information for follow up with the patient. Some patients are not the responsibility of the nurse, for example surgical patients.” (pneumo-oncologist, case 4). Indeed, during our observations in the meetings, the nurse did not contribute to any case discussion and was only taking notes.

Recalling case 6, there is a need for additional administrative support. The MOC chair suggested that a nurse would be the best fit for this position. “We need a person who can support the MOC on an administrative level. I believe an oncological nurse would be the best fit to take up that role.” (MOC chair, case 6).

Second, as indicated previously under the subcategory “hospital policy”, the nurse passes relevant information from the MOC to other multidisciplinary meetings or the wards (case 1 and 2). The nurse in case 5 also presented information on planning appointments for patients, so that other MOC members had a better overview of the patient’s schedule to be taken into account in the treatment plan.

Third, the nurses can act as patient advocates when they believed it is their responsibility to contribute to the discussions with information on their patients’ views.

I believe that when the preferences or wishes of a patient need to be shared, it’s my job to do so if I have that knowledge of the case. The treating physician usually also knows that we, as nurse consultants, have a closer relationship with patients. (nurse consultant 1, case 2).

If I think it is really essential to contribute psychosocial information on a patient to the discussion of the MOC, I will do so. (nurse, case 5)

This vision is shared by some of the physicians. The neurosurgeon in case 10 believed that nurses should actively contribute to the MOC meeting. “They [nurses] should be present to compensate for our shortcomings in the discussions. It’s possible that we think the patient is ready for surgery, while the nurse consultant has been able to talk to the patient multiple times and has a better idea of the patient’s views on the matter.” (neurosurgeon, case 10). Indeed, during our observations, the nurse contributed to the discussions twice. For both cases, the
nurse explained the patient’s view on getting surgery. Both times, the advice of the nurse was taken into account in developing the treatment plan.

**Factors at patient case level**

Making a distinction in patient case complexity can enhance speaking up behaviour of nurses. In case 7 discussions took place between the radiologist, surgeon, radiotherapist, oncologist and pathologist, but the input of nurses is needed in more complex cases. Some contributions by nurses have been observed, especially during more complex cases where input was needed, for example, on the living situation of the patient.

For standard cases, the discussions take place between the main disciplines. When there are other issues like psychosocial, psychological, or other, the nurse and psychologist contribute, and we take that into account in the discussion. (radiologist, case 7).

A similar approach was pursued in case 11, where especially for complex cases nurses have an active role in discussions.

The disciplines who determine the therapy are the radiotherapist and the oncologists. For more complex cases, nurses can provide valuable input. (MOC chair, case 11).

In case 5, we observed that more complex cases took longer to discuss due to input from a larger variety of disciplines including nurses. Having clear indications when the nurses’ expertise is needed in discussions, such as in more complex cases, can provide a framework that is clear for all team members.

Table 3 presents an overview of the facilitating and limiting factors that affected speaking up behaviour of nurses in MOC meetings in the different cases.

**Discussion**

MDTMs have a significant impact on management plans, process outcomes and patient outcomes (Koco et al., 2021). They are increasingly used in oncology (Frisicale et al., 2018). This study looked at the factors that encourage or hinder speaking up of nurses in these settings. Since the patient is not present at these meetings, the participating nurse is best suited as spokesperson for the patient.

As the voice of the nurse is the focal point of our research, we focus on one essential role that nurses have in practice – that of patient advocate. Nurses are expected by their professional code of ethics to intervene on behalf of patients in clinical dilemmas (Pavlish et al., 2011). Although previous studies have argued that nurses are the right profession to act as spokespersons for patients (Wallace et al., 2019; Rosell et al., 2022), it has also been observed that nurses only contribute in a limited manner to case discussions, and that there is inadequate attention paid to the perspective of the patient in MDTMs in oncology (Soukup et al., 2018; Gandamihardja et al., 2019; Rosell et al., 2019; Wallace et al., 2019).

We were able to identify a number of elements that facilitate or limit nurses’ speaking up in MDTMs by attending to factors that affect speaking up and also the characteristics of optimally functioning MOCs. First, nurses perceived their role as observatory, especially when there is another meeting before or after the MOC that involves nurses alone or nurses with the treating physicians. Literature suggests various other reasons for this passive role of nurses, including the MOC being perceived as a purely “clinical” meeting, external barriers like standardization of decision-making, the timing of the meeting in the patient’s trajectory, and internal barriers such as team climate and work experience (Horlait et al., 2022; Baes et al., 2020). Indeed, in the case of hospital A, team members perceived the MOC as the place where only medical information was shared without nurses contributing to the discussions. This role was also perceived as such by other members of the MOC.
Table 3. Factors affecting speaking-up behavior of nurses during MOC meetings

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Speaking up</th>
<th>Not speaking up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors at hospital level</td>
<td>Hospital policy</td>
<td>“They [nurses] should be present to compensate for our shortcomings in the discussions. It’s possible that we think the patient is ready for surgery, while the nurse consultant has been able to talk to the patient multiple times and has a better idea of the patient’s views on the matter.” (neurosurgeon, case 10)</td>
<td>“They never received an invitation. But now as we speak, there might be a new opening into the MOC and there is someone who sees the need for them to join and has a positive attitude towards it.” (MOC chair, case 6)</td>
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<td>“Next to the MOC, there is the multidisciplinary ward meeting, in which psychosocial factors are being discussed more in depth. The MOC is about determining the direction of treatment with only psychosocial factors relevant to that plan.” (nurse consultant, case 1)</td>
<td>“The presence of the nurses is important because they can take information that is being discussed at the MOC back to the team.” (pathologist, case 2)</td>
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<td></td>
<td>“But we do provide psychosocial information to the treating physician before the MOC takes place.” (nurse consultant, case 9)</td>
<td>“The point of my presence is to know which patients are being discussed, how many new cases and how many progressive cases. This is also important for our planning.” (nurse consultant 1, case 1)</td>
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<td></td>
<td>Time constraints</td>
<td>“I don’t have the feeling that nurse consultants have a lot of input, maybe also because there simply isn’t enough time.” (nurse consultant, case 9)</td>
<td>“The onco-coach and psychologist are involved in the discussion of transplant patients, mostly. However, they rarely have time to attend.” (medical oncologist, case 8)</td>
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<td></td>
<td></td>
<td>The load of average number of case per MOC is high. Case 2 and case 3 have respectively on average per hour 19 and 24 patient cases to discuss</td>
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<td>Support</td>
<td>During one observation moment, nurses indicated that not having access to the CoZo online collaborative care platform has slowed down their work and prevented them from preparing properly for the MOC. (Case 10)</td>
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<td>“We lack a person who can support the MOC on an administrative level. . . However, we do not discuss enough patients to receive reimbursement for this position” (MOC chair, case 6)</td>
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<td>Infrastructure</td>
<td>Positioning in the room: in case 1, the nurses sit at the outer corner of the U-shaped table and have their laptops in front of them to take notes during the MOC</td>
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<td></td>
<td>Attendance</td>
<td>Absence (case 6), rarely present (case 8)</td>
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(continued)
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<td>Factors at team level</td>
<td>Team size</td>
<td>In cases 10 and 6, the meeting usually starts on time because there is a smaller number of participants</td>
<td>In MOC meetings with a large number of participants, nurses were more likely to talk to each other instead of with the representative of the other disciplines (observations case 8 and 9)</td>
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<td></td>
<td>Team relationships</td>
<td>“You need to trust everyone’s expertise. When someone makes a suggestion, you have to trust that that is correct.” (oncologist, case 5) “With standard cases, discussions take place between the main disciplines. When there are other issues like psychosocial, psychological, or others, the nurse and psychologist contribute, and we take that into account in discussions.” (radiologist, case 7)</td>
<td>“I think that sometimes hierarchical structures do play a role. We know we can always call the physicians when needed, but for some patients I do have the feeling that I would like to contribute more during the MOC.” (nurse consultant, case 9) “It depends on the nurse who is joining the meeting. Some nurses have more contact with the team than others.” (oncologist, case 12)</td>
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<td></td>
<td>Attitudes of leaders</td>
<td>“If there is really important information that was not shared during the case introduction, then the nurse consultant says so. She will always intervene when something is not clear or complete.” (MOC leader, case 7)</td>
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<td>Leadership</td>
<td></td>
<td>In case 7 our observations revealed that nurses actively contributed to the discussions with information that was usually not shared during the case introduction and the team leader asked for and welcomed these contributions</td>
<td>“There is no MOC chair to lead the discussions and to keep an eye on the timing, and I personally think this is crucial to the functioning of the MOC.” (nurse consultant 1, case 2) “There is no true MOC chair. It isn’t clear to me who holds this title at the moment.” (nurse, case 5)</td>
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<td>Professional roles</td>
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<td>“I believe that when the preferences or wishes of a patient need to be shared, it is my job to do so, if I have that knowledge of the case. The treating physician usually also knows that we as nurse consultants have a closer relationship with patients.” (nurse consultant 1, case 2) “If I think it is really essential to contribute psychosocial information on a patient to the discussion of the MOC, I will do so.” (nurse, case 5) “They [nurses] should be present to compensate for our shortcomings in the discussions. It’s possible that we think the patient is ready for surgery whilst the nurse consultant has been able to talk to the patient multiple times and has a better idea of the patient’s views on the matter.” (neurosurgeon, case 10)</td>
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<td>Factors at patient case level</td>
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<td>“The MOC is a medical meeting, which is mostly about surgical matters. . . . I’m a nurse consultant, my job is not to contribute to discussions but only to absorb the information that is discussed.” (nurse consultant 2, case 2) “We lack a person who can support the MOC on an administrative level. I believe an oncological nurse would be the best fit to take up that role.” (MOC chair, case 6)</td>
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</table>

Source(s): Adapted from Okuyama et al. (2014) and Horlait et al. (2021)
Secondly, as shown in hospital B, hierarchy can play a role in the extent to which nurses feel free to contribute to the discussions. Voice barriers can be affected by status differences between physicians and nurses (Nembhard and Edmondson, 2006; Wilkinson et al., 2020b). Reluctance to speak up has furthermore been linked to team-level psychological safety (Nembhard and Edmondson, 2006). Nevertheless, nurses are more likely to advocate for patients in the decision-making process (Soukup et al., 2018; Lamb et al., 2011b), which reinforces the importance of equal participation (Brown et al., 2022).

Thirdly, MOC chairs play an important role in these meetings. Within an MDTM, the chair is in a position to shape the communication culture and lower voice barriers that are enabled by status and professional position (Wihl et al., 2020; Nembhard and Edmondson, 2006). Chairs must possess adequate skills to ensure and stimulate interaction and collaboration between team members, and need to pay attention to improvement and development aspects (Wihl et al., 2020). In particular, it is important to keep in mind that physicians traditionally learn independently in a highly competitive academic environment, implying that sharing leadership with others can be a challenge (Wihl et al., 2020; Wilkinson et al., 2015). Future training programmes for MDTM leaders could be a tool to further stimulate multidisciplinary discussions and enhance speaking up by nurses. Likewise, a mentoring programme could enable nurses to increase their contribution during MDTMs. Learning good practices from each other can also be a valuable approach (McDermott, 1999).

Another factor to be taken into consideration is the division between straightforward and complex cases. This study has demonstrated that nurses tend to contribute more to the discussion in complex cases. We argue that this is due to the need to address broader issues for this cases at the meeting. Oncology nurses involved in multidisciplinary teams focus on complex patient-centred information such as co-morbidities, psychosocial and supportive care needs, and patient preferences (Komatsu and Komatsu, 2023). Furthermore, research suggests that, by making a division based on case complexity, more time and resources can be devoted to the complex cases (Lamb et al., 2014). Using such a division could provide nurses and MDTM members with a clear framework as to when their input is needed, potentially lowering the moral distress around speaking up. In this vein, it could be beneficial to use tools designed for team discussions in MOCs. The MDT-MeDiC tool rates cases based on complexity and can assist as a screening tool for case prioritization (Soukup et al., 2020). Likewise, the MDT-QulC checklist (Lamb et al., 2012) provides a structured manner that supports the discussion and decision-making processes during MDTMs.

In voicing literature, two concepts can be found, “employee voice” and “safety voice”, the distinction between which is not always clear (Noort et al., 2019). Employee voice can be described as the casual and optional sharing of thoughts, recommendations, worries, difficulties, or viewpoints on work-related conditions and issues (such as rosters, leave, entitlements, etc.), with the aim of fostering enhancement or alteration (Dyne et al., 2003), while safety voice is the act of speaking up about safety in order to prevent accidents and physical harm to patients (Noort et al., 2019). The two concepts overlap because both refer to extra-role communicative acts that address perceived issues and changes to the status quo (Noort et al., 2019). In a similar way, speaking up to enhance patient-centeredness finds connection with both concepts. On the one hand, employees need recognition and support from the organisation, where the organisation must create the right conditions so employees dare to speak up. On the other hand, the stakeholder is the patient, which closely relates to the patient safety perspective. Our study illustrates that nurses can assume the role of patient advocate and demand to have a say from the “safety” aspect, in order to develop a treatment plan tailored to the patient, and from the “employee” aspect, it is crucial to empower nurses to effectively take on that role within the team.

Following, Wilkinson et al. (2020b) propose approaching the rather abstract conceptualization of voice with clear and concrete contextual detail. They argue that an effective voice system is one that is balanced in that it involves different perspectives
(Wilkinson et al., 2020b). Therefore, we distance ourselves from the within-silos approaches to voicing by contextualizing voicing in a healthcare setting where hierarchy is in place through interdisciplinary team meetings.

**Limitations**

This study has several limitations. As in all observational studies, participants may alter their behaviour simply because they are aware they are being observed. This can lead to an artificial representation of their usual behaviour.

The observations took place in two hospitals in Flanders: one regional and one academic hospital. More regional and academic hospitals should be included in future research in order to determine whether there is a difference between the characteristics of efficiently functioning MOCs. Further, cultural differences also need to be taken into account. However, our findings are in line with those of the international literature, emphasizing the need for further research on nurse involvement in MDTMs.

In accounting for the professional roles of nurses in our study, we distinguished different nursing profiles: oncological nurses or onco-coaches, who have a bachelor’s degree and supplementary oncological training, who fulfil a care function and clinical nurse specialists, who have a higher academic degree and who play a coordinating function. This is a significant simplification of the situation in oncological nursing in Belgium, where a wide range of titles, qualifications and duties make differentiation difficult (see Table 1). Future research could identify which nursing profile fits best in MDTMs.

**Conclusion**

The roles currently played by nurses in MDTMs are mainly observatory, in spite of a clear need for nurses pursuing more active contributions, in particular for complex cases. The provision of psychosocial information on patients was singled out as being essential, and nurses are a good fit to take responsibility for this. By taking into account factors that affect speaking up (i.e. team relationships and leadership) and the characteristics of optimally functioning MOCs (such as support tools, infrastructure, administrative support and team size), we succeeded in identifying a range of elements that facilitate or limit nurses’ speaking up in MDTMs. Likewise, professional roles, time constraints and case complexity affect the speaking up behaviour of nurses. MDTM team members should be enabled to develop a shared understanding of the role of nurses in the meetings. More research on tools and mentoring programmes that would further empower nurses to contribute at MDTMs, is needed.

**References**


Wallace, I.G. (2017), *Multidisciplinary Team Meetings in Cancer Care: A Qualitative Study of the Role of Status Hierarchies in the Decision Making Process*, University, College London.


**Appendix**

(1) What is your specific function within the MOC?

(2) Are all patients discussed in the MOC?

**Discussion of patients**

(1) Is there a specific order used for discussing the cases?

(2) Are all patients discussed equally?

(3) Do you feel that each patient is adequately discussed?

**Structure MOC**

(1) Do you like the structure of the MOC? And why?
(2) Are you notified in advance if the representative of a particular discipline will be absent?

**Efficiency MOC**

(1) What do you think contributes to an efficient MOC, overall?
(2) What makes the participants in a MOC work well together? (e.g. teamwork or mutual cooperation).
(3) If there is a difference in decision-making or consensus is not reached, how is that resolved/noted?
(4) Are there any elements that you find disturbing during MOCs?

**MOC contribution**

(1) Do you agree that not everyone contributes equally in the MOC?

**Atmosphere/culture in the MOC**

(1) How would you describe the atmosphere or culture in your MOC?
(2) Is there enough respect for each participant?

**Chair qualities**

(1) What qualities should a good chair or leader of the MOC have?
(2) Does the chair of your MOC have these qualities?
(3) What is the difference between the MOC chairperson and the coordinator of the tumour working group?

**Content**

(1) In your opinion, are the psychosocial context and patient perspective adequately addressed during the MOC?
(2) Is there an evaluation sheet that considers whether all necessary information from each patient has been adequately discussed? Or to check whether all (nonmedical) factors are addressed during the MOC?
(3) Would it be a solution to work with a checklist during the MOC?

**Decision making**

(1) What are the main reasons for not implementing the recommendations of the MOC?

**Infrastructure and physical environment**

(1) Is there a significant physical barrier to the efficient/effective running of the MOC in the room where it takes place?
(2) Who has access to e-health platforms and the EPD (visualization/image programs) for displaying imagery?
(3) Is videoconferencing or teleconferencing used? If not, is that an advantage or a disadvantage, in your opinion? Why?
(4) What additional technology do you think could improve the effectiveness/efficiency of a MOC?
(5) Is there any budget for this?

**MOC organization, administration and preparation**

(1) Who organizes the MOC?
(2) What preparation needs to be done before the MOC so that the MOC can run efficiently?
(3) Do you think you have enough time to prepare the MOC?
(4) Do you think the timing of the MOC is good?
(5) Are there sufficient resources available to continue running the MOC as it is run now?

(6) Are the current available resources (number of staff, time, funding) sufficient to perform your task in the MOC?

(7) Is there anything related to resources that you could change to support your function?

(8) Do you think there is sufficient organizational support from the administration?

Evaluation of MOC operation

(1) Is there an annual audit or evaluation regarding the MOC, separate from the registration of the cancer registry?

(2) If there is, who runs it? (the team itself, an external party?)

(3) If there is not, could such an evaluation enhance the efficiency of the MOC?

(4) Is there any feedback from the recorded data (e.g. cancer registry) to the tumour group?

(5) Does feedback from the referrer to the MOC happen after advice is given?

(6) Does the MOC assess its own effectiveness/performance, and are these assessments compared with those of other MOCs?

(7) In your opinion, what other measurement tools, other than observation and interviews, could be used to evaluate the performance of the MOC?

Workload

(1) Does the MOC aggravate or relieve your workload?

Registration of patients

(1) Can patients who are not legally required to be discussed in a MOC be added on a MOC list for discussion?

(2) How are patients registered for discussion at a MOC?

General

(1) If there is one thing you could change to make this MOC more efficient, what would it be?

(2) What would help to improve your (personal) contribution to the consultation?

(3) What forms of training, education, or tools would you or the team consider useful to support an efficient MOC?

(4) Is there any training that would enhance collaboration between different disciplines to help run the MOC more efficiently?

(5) What are the pros and cons of MOCs, in your opinion?

(6) Do you have any comments to add?

Source(s): Interview guide based on criteria from the characteristics of an effective multidisciplinary team NCAT (2010)

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