Are members of multidisciplinary teams in breast cancer aware of each other's informational roles?

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Abstract

Aim—To conduct a commissioned survey of multidisciplinary breast team members' expectations of their own and each other's roles in providing different kinds of information to women with breast cancer.

Design—Questionnaire based survey.

Setting and participants—Health professionals from five multidisciplinary breast care centres within a Sussex health authority.

Main outcome measures—Interdisciplinary awareness of informational roles played by different team members.

Results and conclusions—The results of the team survey suggest that, in most cases, health professionals fulfilled the roles expected of them by the team, with two or three individuals identified as the main providers of information for each topic. However, many more professionals were involved in major discussions without the team's knowledge. The professional consistently playing a major "unseen" role was the breast nurse specialist.

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Keywords: multidisciplinary teamwork; breast cancer; communication

Research in the primary health care setting highlights a number of benefits for professionals working within a supportive, well functioning team, including better mental health and increased team effectiveness.¹ Complex tasks are accomplished more easily when professionals within the health care teams have clear goals, are cooperative and mutually supportive of one another, and are aware of each other's role.^{2,3} In order to achieve this, team members need to be able to communicate clearly within and across the different professional disciplines and with the patients. There is plenty of evidence from hospitals and medical defence organisations showing that poor communication in general results in complaints and litigation.⁴

Inadequate communication between members of specialist cancer teams can lead to confusion for patients about diagnoses, prognoses, and future management plans. Not only does

Key messages

- Most cancer services are now delivered by multidisciplinary teams (MDTs) but the putative benefits of this approach have not been systematically evaluated.
- There is evidence from our pilot study that many members of breast cancer MDTs are unaware of the informational roles of colleagues.
- If patients are to receive comprehensive and consistent information, teams may require extra training, particularly with communication skills, in how to work together as a team.
- Resources must be allocated for training if benefits of MDT working are to be realised.

this cause unnecessary distress for patients, but the situation is also frustrating and professionally unrewarding for team members. 39% of senior oncology nurses and 25% of doctors attending our communication skills courses cited "communication with colleagues" among their most stressful and challenging concerns.⁵ In addition, poor communication and management skills training were identified as major factors leading to burn out and psychiatric morbidity in UK consultants.⁶

Since publication of the Calman-Hine report concerning reorganisation of cancer services in the UK, many centres have adopted a multidisciplinary team (MDT) approach with the aim of providing the patient with the best care.⁷ The NHS Executive breast cancer guidelines and those of the Scottish Intercollegiate Network made explicit recommendations about the need for good communication between the healthcare professionals within an MDT, and between the MDT and patients.^{8,9} A well functioning MDT with good communication skills should prevent or ameliorate some of the problems experienced by patients and their professional carers through increased efficiency, improved morale, and work satisfaction. Few data are currently available to show how well this is being achieved and there has been no systematic examination of the advantages and disadvantages of an MDT approach to cancer care. The East Sussex, Brighton and Hove health authority therefore commissioned an in depth survey with five multidisciplinary breast

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care teams from the Brighton, Eastbourne, Hastings, Haywards Heath, and Worthing hospitals.

We present preliminary data that examined MDT members' expectations of their own and each other's roles in providing different kinds of information to women with breast cancer.

The objectives of the survey were:

- to examine whether an individual team member's perceived actual role in the provision of information to women with breast cancer matched the expectation of the team;
- to determine whether or not the MDTs across Sussex provided the same type of information to patients with breast cancer;
- to identify potential areas of omission or inconsistency of information within and across the teams.

Methods

SURVEY INSTRUMENT

A two part questionnaire was designed specifically for use in this project by the authors and was based on the information that a woman with breast cancer may be given during her disease trajectory (appendix 1). The form was modified by the authors after pilot testing for clarity and comprehensibility in two MDTs, one in Scotland and another in the south east of England. Part 1 established health professionals' views of the areas in which they considered **themselves** to have **major** responsibility when providing information to patients. Part 2 revealed each team member's views of their **colleagues'** informational roles. The term **major role** referred to "a role that requires you to give detailed professional information to a patient" (information sheet, appendix 2).

The information areas covered on the questionnaire were diagnostic tests, test results, chemotherapy, radiotherapy, staging investigations, surgery, breast reconstruction, prognosis, family history, hormone therapy, prostheses, and clinical trials. In addition, each team member was asked to indicate who had a major role in discussing psychosocial problems concerning physical, functional, sexual, social, and emotional well being. Responsibility for the provision of information leaflets was also probed.

One of the authors visited each of the five teams nominated by the funding health authority to explain the nature of the survey. Multiple regional and local ethical approval was sought for each team that consented to the study. The authors sent the self-report questionnaire to all the health professionals in the five breast care teams. The team members read an information sheet and gave written consent before participating in the survey.

THE MULTIDISCIPLINARY TEAMS (MDTs)

Five MDTs ranging in size from six to 19 members within one large health authority took part in the study between February 1999 and August 1999. The numbers and professional discipline of survey participants who regularly attended weekly MDT meetings are shown in table 1. All teams contained at least

Table 1 Personnel attending multidisciplinary breast team meetings who participated in the survey

Team	A	B	C	D	E	Total
Surgeons	3	1	2	1	2	9
Oncologists	1	1	1	1	1	5
Radiologists	1	2	2	1	1	7
Breast care nurses	3	2	1	1	3	10
Radiographers	5	2		1	9	17
Nurse practitioners	1					1
Chemo nurses			1			1
Clinic nurses	1	2			2	5
Ward nurses				1		1
Breast physician	1					1
Trials staff					1	1
Total	16	10	7	6	19	58

one surgeon, oncologist, specialist breast care nurse, radiologist, and radiographer. The bigger teams included clinic, ward, and chemotherapy nurses and a trials coordinator.

ANALYSIS OF DATA

For each professional discipline the frequency of responses for each information area was recorded. For example, if five out of nine surgeons identified discussing clinical trials with patients as a major role, it was reported as such for that professional group. Similarly, if 50% or more of the teams believed radiographers gave information leaflets to patients, it was reported as an expected major role for that professional group. This allowed us to compare and contrast the views of each professional group within and between teams. Individual reports were produced on each team for the health authority but for this paper the data from all five MDTs are presented.

Results

MULTIDISCIPLINARY TEAM DATA

Questionnaires were sent to 64 individuals identified as members of their local MDTs. The overall response rate was 58/64 (91%); four surgeons, one chemotherapy nurse, and one radiographer failed to return questionnaires.

HOW DIFFERENT PROFESSIONAL SPECIALTIES WITHIN MDTs SAW THEMSELVES

There was some variance within each professional specialty regarding the perceived extent of their informational roles, as shown in table 2. For example, while all nine surgeons in the MDTs saw themselves as having a major role in the provision of information in four areas pertaining to tests, primary surgery, and staging, one individual surgeon from one of the largest MDTs believed that he had a major responsibility for 15 areas. Likewise, certain oncologists and specialist breast care nurses perceived themselves as having more extensive roles than others from the same professional disciplines working within different teams.

TEAM MEMBERS' EXPECTATIONS VERSUS INDIVIDUALS' PERCEIVED MAJOR ROLES

There were discrepancies between MDT members' expectations of the roles of others compared with individuals' perceptions of their own role. The largest number of discrepancies between expected and perceived major roles

Table 2 Perception of informational major role by specialty

	Surgeon (n=9)	Oncologist (n=5)	Breast care nurse (n=10)	Radiologist (n=7)	Radiographer (n=17)	Clinic nurse (n=5)
Diagnostic tests	9 (100%)	4 (80%)	10 (100%)	5 (71%)	1 (6%)	
Test results	9 (100%)	2 (40%)	7 (70%)	4 (57%)	16 (94%)	3(60%)
Surgery	9 (100%)	2 (40%)	10 (100%)			2(40%)
Prostheses	4 (45%)	2 (40%)	8 (80%)		1 (6%)	1(20%)
Reconstruction	5 (56%)	2 (40%)	9 (90%)			
Radiotherapy	2 (22%)	5 (100%)	8 (80%)		3 (17%)	
Chemotherapy	1 (11%)	5 (100%)	8 (80%)		1 (6%)	
Hormone therapy	7 (78%)	5 (100%)	10 (100%)		2 (12%)	
Prognosis	8 (89%)	5 (100%)	8 (80%)	1 (14%)	1 (6%)	
Staging	9 (100%)	5 (100%)	7 (70%)	4 (57%)	1 (6%)	2(40%)
Clinical trials	5 (56%)	4 (80%)	6 (60%)	1 (14%)		
Family history	6 (67%)	4 (80%)	5 (50%)	3 (43%)	1 (6%)	
Info leaflets	4 (45%)	3 (60%)	9 (90%)	2 (29%)	9 (53%)	3(60%)
Physical well being	7 (78%)	4 (80%)	10 (100%)		3 (18%)	2(40%)
Functional well being	6 (67%)	4 (80%)	10 (100%)		3 (12%)	2(40%)
Sexual well being	2 (22%)	4 (80%)	10 (100%)		1 (6%)	3(60%)
Social well being	3 (33%)	2 (40%)	9 (90%)		2 (12%)	2(40%)
Emotional well being	2 (22%)	3 (60%)	10 (100%)			3(60%)

Table 3 Professionals who perceive themselves as having a major role but are not expected to do so by the team

Diagnostic tests	Oncologist in 1 team; radiographer in 1 team
Test results	Breast care nurse in 3 teams; radiologist in 1; clinic nurse in 2 teams
Surgery	Breast care nurse in 2 teams; oncologist in 2 teams; clinic nurse in 1 team
Prostheses	Surgeon in 1 team; oncologist in 2 teams
Breast reconstruction	Oncologist in 2 teams
Radiotherapy	Breast care nurse in 1 team; radiographer in 1 team
Chemotherapy	
Hormone therapy	Breast care nurse in 1 team
Prognosis	Breast care nurse in 3 teams
Staging investigations	Oncologist in 1 team; breast care nurse in 3 teams; radiologist in 3 teams; clinic nurse in 1 team
Clinical trials	Oncologist in 1 team; breast care nurse in 2 teams; radiologist in 1 team
Family history	Oncologist in 3 teams; breast care nurse in 2 teams; radiologist in 2 teams
Information leaflets	Surgeon in 1 team; oncologist in 3 teams; radiologist in 2 teams; radiographer in 2 teams
Physical well being	Clinic nurse in 1 team; radiographer in 1 team
Functional well being	Oncologist in 1 team; clinic nurse in 1 team
Sexual well being	Clinic nurse in 2 teams
Social well being	Surgeon in 1 team; oncologist in 1 team; clinic nurse in 1 team
Emotional well being	Oncologist in 3 teams; clinic nurse in 1 team

occurred for the specialist breast nurses in most information areas other than in the discussion of psychosocial issues, as can be seen in table 3. Their role in the discussion of test results, staging investigations, and prognosis was underestimated by three of the five teams. The clinic nurses also perceived themselves as having a major role in discussions about tests and psychosocial concerns which was not acknowledged by other team members. In addition, some of the informational roles claimed by the radiologists and the radiographers appeared to go unrecognised by the majority of their teams. There was some confusion surrounding the discussion of family history and clinical trials. In four of the five teams the surgeon was nominated by more than 50% of the team as the professional who was expected to discuss family history with patients. However, many other team members—for example, four of the oncologists, six breast care nurses, and one radiologist (see table 3)—believed they had a major role in these discussions.

Discussion

The results of the survey suggest that, in the majority of cases, the health professionals fulfilled the roles expected of them. Usually two or three individuals, often the surgeon, oncologist and specialist breast care nurse, were identified as the main providers of information for each topic. However, the survey revealed that many more professionals were involved in major discussions without the

rest of the team's knowledge. The professional consistently playing a major "unseen" role was the breast nurse specialist. It appeared that the team viewed her as playing a major role in the discussion of psychosocial problems with patients but a more supportive role to clinicians in the discussion of diagnosis and treatments. Discrepancies such as these reveal a lack of interdisciplinary awareness and were far more common than completely failed role expectations. The finding causes some concern as it may suggest that an individual is unsure of his or her role and so compensates by trying to cover all the information areas. A failure by the team to outline clear role boundaries can lead to burn out in some individuals or feelings of being undervalued. If this situation is left unchecked it can result in discontentment, ill will, and poor staff morale. There is also the potential for the provision of contradictory information being given to patients about their tests and treatments if team members have little idea as to what their colleagues are covering. These findings complement the review by Carter and West¹ on team work. They suggest that role ambiguity and conflict are linked up in the historical and structural attitudes of professions working within the teams—for example, the doctor-nurse status.

There were three areas of information that were not well addressed by some of the teams. One of these was the discussion with women of the risk of breast cancer developing in other family members. Although risk perception is a difficult concept, it is listed as an important

priority for women after receiving information about chances of cure and spread of disease.¹⁰ Another was in the discussion of clinical trials. There was some discrepancy between those professionals who perceived themselves to be involved with trials and those identified as doing so by the team, suggesting that perhaps the recruitment of women to clinical trials for breast cancer therapy is not a routine event in this health authority, a suggestion that is supported by the Thames Cancer Registry¹¹ which examined the management of breast cancer in south east England. A final problem area was in the discussion of sexual problems with patients. Sexual problems occur frequently in breast cancer patients because of surgery and treatment and often extend beyond the initial phase of treatment.¹² Yet, traditionally, social well being, body image, and sexual functioning are neglected areas of discussion between patients and health professionals.^{13 14} Studies reveal that most women who experience sexual problems have not been asked by their doctor or nurse about sexual functioning.^{15 16} One reason may be that health professionals feel embarrassed or inadequate about dealing with such issues. However, sexuality and intimacy are important concerns for breast cancer patients and should be addressed. These findings were reflected in the views of a convenience sample of women with breast cancer being treated by each of the teams.

An important aim of the study was to examine whether an individual MDT member's perceived role in the provision of information to women with breast cancer matched the expectation of the team. The survey established whether or not the same type of information was being provided to patients across the region by breast cancer MDTs and if areas of omission or inconsistency of information could be identified. In most cases the different health care professionals fulfilled the roles expected of them by the team and appeared to provide a reasonable information service to the patients with certain omissions that need rectifying.

Effective MDT functioning is important not only for the benefit of patients, but also for the efficiency, morale, and work satisfaction of the individual team members. Results from projects such as this will help inform the development of the breast care pathways, clearly delineating each professional's responsibility for information provision. It is disappointing that no resource has been provided for any training to accompany the recommendations made by the NHS Executive (and Scottish equivalent). We have recently conducted two pilot studies of a training workshop for breast

MDTs in Edinburgh and Portsmouth. A random sample of consenting patients with established disease and awaiting assessment in breast units had all their interactions with individual team members videotaped. The women were briefly interviewed after each interaction to find out what information the women recalled and by whom they thought they had just been seen. These tapes were then reviewed by two of the authors of this paper and edited to show examples of good agreement, overlap, omission, and/or potential confusion. These video clips were shown at the away day, together with team members' questionnaire data. Ways to improve communication between the team and with their patients were then discussed in a constructive manner. Feedback from the away days has been very positive and we hope that this initiative will be supported for further work throughout cancer centres in the UK.

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Appendix 1: Multidisciplinary Team Questionnaire

CONFIDENTIAL

Name.....

Specialty

Hospital

Who is the lead clinician for your multidisciplinary team?.....

Who regularly attends your multidisciplinary team meeting? (Please indicate in each box how many individuals from each specialty attend)

Surgeon
 Medical Oncologist
 Clinical Oncologist
 Specialist Breast Care Nurse
 Research Nurse
 General Practitioner
 Clinic Nurse
 Diagnostic Radiologist
 Radiographer
 Pathologist
 Counsellor
 Psychiatrist/Clinical Psychologist
 Chemotherapy nurse
 Ward Nurse
 Other (please specify)

CONFIDENTIAL

Name and Designation

Hospital

PLEASE TICK WHICH OF YOUR TEAM MEMBERS (INCLUDING YOURSELF) has a MAJOR ROLE in providing information to women with breast cancer in each of the following areas. (You may tick more than one box for each area).

	Surgeon	Oncologist	Breast care nurse	Radiologist	Radiographer	Research nurse	Clinic nurse	Ward nurse	Chemo nurse	Other (please state)
Diagnostic tests										
Test results/diagnosis										
Surgery										
Prostheses										
Breast reconstruction										
Radiotherapy										
Chemotherapy										
Hormone therapy										
Prognosis										
Staging investigations										
Clinical trials										
Family history										
Information leaflets										

PLEASE TICK WHICH OF YOUR TEAM MEMBERS (INCLUDING YOURSELF) has a MAJOR ROLE in discussing patient problems in the following areas. (You may tick more than one box for each area).

	Surgeon	Oncologist	Breast care nurse	Radiologist	Radiographer	Research nurse	Clinic nurse	Ward nurse	Chemo nurse	Other (please state)
Physical well being (i.e. pain, side effects, lethargy)										
Functional well being (i.e. work, sleeping)										
Sexual well being (i.e. attractiveness, personal relationships)										
Social well being (i.e. social activities, relationship with family and friends)										
Psychological/ emotional well being (i.e. depression, anxiety, hope)										

Consent to Research Project

Have you read the information sheet? Yes No

Have you had the opportunity to ask questions and discuss this study?

Have you received enough information about the study?

Do you agree to take part in the study?

Signature.....

Name in block letters.....

Specialty

Date.....

Appendix 2: Information Sheet for Health Professionals

We would like to invite you to take part in the above research study and this information sheet explains what it is about. Please feel free to contact the investigators if you have any questions at all.

Aims of the study

- to examine the attitudes and ideas of a specialised team regarding information and communication needs of breast cancer patients
- to assess the accuracy and consistency of information delivered within a specialised breast unit
- to develop training initiatives based on findings above to improve multidisciplinary teams' communication with each other and with patients.

Who is taking part?

A number of specialist breast care centres in the UK

What does it involve?

You will be asked to complete one form which examines

- (a) your major role in providing information to women with breast cancer;
- (b) the major role of your team members in providing different types of information.

The term **major** refers to any role that requires you to give detailed professional information to a patient. This form will take approximately 20 minutes to complete.

Confidentiality

We assure all participants that the written report and any subsequent publication of results will ensure that individuals will neither be identified nor identifiable.

Thank you very much for your help.

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