COVID-19 and the multidisciplinary team meeting: 'Should old acquaintance be forgot?'

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Keywords: COVID-19, multidisciplinary team meeting

Financial and Competing Interests: GPC is the Education Editor of the *Journal of the Royal College of Physicians of Edinburgh* (*JRCPE*). This paper has undergone peer review in accordance with *JRCPE*'s policies.

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In healthcare, a multidisciplinary team (MDT) constitutes a group of individuals working collaboratively from different disciplines who discuss and decide the most appropriate investigations and optimal management of patients.[1] MDT meetings help synthesise the collective knowledge, experiences and opinions from a range of specialists with the ultimate aim of streamlining the management of both acute and chronic medical conditions and disease processes. Its ultimate aim is to improve outcomes in a holistic bespoke manner. In recent times, there has been an explosion in all areas of healthcare where the MDT has a prominent and pivotal role to play, with such a process often being recommended by national guidelines and considered to represent a 'gold standard' prerequisite.[1,2] A slowly increasing rich breadth of data demonstrate that MDTs can improve patient-centred outcomes,[3–4] while 'softer' benefits such as education and training opportunities, fostering of relationships and enhanced interprofessional communication, a sense of 'being included', and team working are likely to occur.

The COVID-19 pandemic has necessitated a major change in the MDT landscape. Historically, most MDT meetings were likely to have involved the majority of participants congregating in the same room allowing ease of contribution and participation. However, the need to socially distance and national governing bodies advocating working at home wherever possible, have meant that virtual MDTs have now become commonplace, verging on the norm in many circumstances. Given such a major change in the working patterns of MDTs and its participants has evolved through necessity in a short period of time, it has become gradually apparent that both benefits and drawbacks occur (Table 1). Moreover, uncertainty exists as to whether the remotely operating MDT should remain, and, if so, what factors need to be put in place in order to optimise the smooth running of the process and ensure outcomes are similar to the pre-COVID-19 era. Different software platforms also exist that all have differing advantages and disadvantages.[5] For example, Microsoft Teams has gained widespread popularity by the UK National Health Service (NHS) and is generally accepted to be secure and reliable. It also boasts other benefits, all of which are designed to aid communication and networking. Commercial platforms such as Skype and Zoom tend to be less secure and currently not advocated for use in the NHS.

Unfortunately, few data exist that support the notion that virtual MDT working should either remain or gradually metamorphose back into the traditional model. However, one small questionnaire study explored opinions after eight virtual MDTs. Of respondents (n = 36), 73% and 83% considered that the depth of discussion and decision-making processes had not changed versus the traditional MDT.[6] In a further study,[7] a questionnaire was distributed to all head and neck MDTs in the UK, of which there were 97 responses. Most respondents (70%) considered that decision-making was unchanged, while 85% felt that technology was satisfactory, and approximately three quarters felt that some aspects of communication (for example viewing of images and slides) were 'as good' or 'better'. However, it was felt that engagement, team working and training were poorer versus traditional working.

If virtual MDTs are here to stay for the short to medium term, drawing up and widespread adherence to a list of 'rules of engagement' need to be considered. Any such guidance is likely to be dynamic, and vary between institutions and subject nature of the MDT. However, it seems reasonable to consider that such 'rules' can be categorised as healthcare institution, local organisational and participant specific (Table 2). It does need to be borne in mind that while virtual attendance is comparatively easy and can occur within the confines and comfort of an individual's own home, ability to pay attention and avoid distractions are far more challenging to practice and sustain.

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Table 1 Advantages and disadvantages of virtual multidisciplinary team meetings

Advantages	Disadvantages
Facilitates social distancing	Distractions/multitasking (e.g. dealing with non-MDT administrative work, replying to emails and text messages)
Allows remote/off site participation	Depersonalisation/lack of personal interaction
Allows use of the 'chat'/and 'hands up' functions without MDT disruption	Suboptimal collaborative experience
Ability to access other data systems during patient discussion to enhance decision-making	Technological issues resulting in impaired audio-visual communication hampering and/or prolonging discussion
	Not adhering to virtual working etiquette

Table 2 Suggested prerequisites of an ideal multidisciplinary team (MDT) meeting

Healthcare institution	Local MDT organisation	Participant
Commitment to virtual MDT working	Appointed chairperson/MDT lead	Continual visual presence and concentration
Financial investment into audio-visual hardware and software platforms	Audit of participant attendance/ contribution	Avoidance of multitasking
Ensuring participants have access to fit for purpose desktop/laptop computers, speakers and cameras	Accurate documentation	Muted microphone unless speaking
A simple, user friendly, reliable and effective technological platform	Knowledge of how and where to get help quickly in event of audio-visual disruption	Awareness of, and adherence to, virtual working etiquette
	Frequent checking that all participants are able to hear/see	Use of a 'blurred' background
	'Sign in' and 'sign out' feature	No environmental distractions
	Use of an attendance sheet	Ability to participate without concerns of confidentiality loss

In summary, it is likely that remote working MDTs are here to stay in some form or another. In some institutions, as restrictions continue to ease, increasing numbers of MDT participants may decide to collectively congregate once again. Further larger studies are required into the acceptability and effectiveness of virtual MDTs to all participants, and whether or not the virtual platform has any bearing on meeting duration; perhaps one further unexplored facet is what the extent of different team members verbal contribution is altered by the virtual versus the traditional model. As the use of virtual platforms continues to increase exponentially in healthcare systems, not only for MDTs, but meetings and communication in general, let us all continue to reflect and ask ourselves: Am I essential to this meeting? Am I paying attention? Am I contributing? Am I adhering to appropriate etiquette? Would the MDT experience be better (and feasible) in a non-virtual room? And, finally, as the new light of 2022 beckons, let us all keep in mind the rhetorical question – which can equally be applied to the pre-COVID-19 MDT – posed by Robert Burns in Auld Lang Syne. In his world famous song he laments 'Should old acquaintance be forgot, and never thought upon?' which, according to Wikipedia translates roughly as 'is it correct that old times are forgotten?'.

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