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Multidisciplinary Team Meeting in UK Geriatric Medicine

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Abstract

Value of multidisciplinary working teams has become more recognized to provide better healthcare service for the patients. Good communication within healthcare profession in regular meetings is the cement that holds the team together. There are various models of MDT meeting and there are issues that can rise in each model however with better communication and interpersonal skills, working-group can overcome these obstacles. A survey conducted to extrapolate UK geriatrician opinion in their current MDT meeting at their hospital and unit; emailing a questionnaire to analysis their responds.

Results: There are acceptance levels among British geriatrician in their current MDT meeting level and outcome.

Introduction

MDT is a method to bring different professionals to provide coordinated or integrated service to a client or clients [1]. Establishing interdependent work and regular meetings between the disciplines is essential to ensure that the best quality of care is provided to patients [2,3].

Models – advantages and apprehending issues

There are many forms of MTD workings and meetings and can be classified [1] according to their:

- Disciplines: for example, doctors, nurses, therapists and managers
- Specialties as physicians, surgeons and psychologists
- Ranking, i.e., junior and senior levels.

It also can be classified into inter-departmental forms; ward-based working group is an example. While in trans-departmental or trans-disciplinary communication requires interdependent decisions between different clinical specialities to reach appropriate diagnosis and treatment [4].

Inter-departmental, interdisciplinary and multidisciplinary are all terms referring to group workings and sharing a common physical space. Wilson and Pirrie [1] quoted from Pirrie et al.; 'interdisciplinary… it's like you are crossing into another space' Therefore, an individual from a medical allied professional can advise, enforce and express value in managing patients. The problems are intervening in each other's professional territories and culture [1], when they may not share a common understanding. There are different priorities between medical professionals and health allies in providing care service [5].

The issues that arise in trans-disciplinary working group are the diversity in medical concepts. For example, while a neurologist tries different medications to control Parkinson syndrome, the geriatricians are more concerned with old people's quality of life and drug interaction [4]. Another concern is the attitude toward the collaborative work. The authoritarian attitude, especially among medical professions, can restrict tolerance and interfere with feed-back from other specialists on their performance [4]. Long years of studying and training in the medical field have led to an increased sense of professional autonomy. For example, surgeons and orthopaedic specialists feel that they have greater leadership roles in their operating patients' management than ortho-geriatricians or medical rehabilitation physicians.

Teams almost always consist of different training levels. Orders and negotiations are not uncommon in hospital wards [4], as suggested by Le Grand, that knights and knaves co-exist within NHS, at different levels and among all the groups. Delegating jobs, responsibilities and authorities is a daily practice among health professions. For example, senior nurses are delegated for administrative works, leaving patients' care for junior and student nurses. Hierarchy and power differentials, instead of providing mentor for training professions [6], can produce stress and discomfort among a group; this is more experienced with situations of uncertainty and with increased work-loads.

Solution

Developing a common focus and growing sense of interdependence are essential to reach a consensus on a management plan – not only working in one unit or sharing the same physical space. Institutions [7,8] and their personnel [9,10] are relied on for accomplishing this.

Commitment from whole teams and good leadership are fundamental to building a MDT environment. Developing a learning and listening culture paves the way for establishing a consensus on principles and sharing a common vision [1,9].

Good communication in hospital-wards with regular meetings is the cement that holds the team together, clarifying dynamic roles for each and every member in every case for the best interest of the patients [1]. Individuals reflecting on their practice will develop and extend their role as overall changes take place in healthcare professions [11]. For example, physiotherapists have the role of diagnosing orthostatic hypotension and postural instability that may regard as a medical issue. The occupational therapists have roles to assess cognitive impairment and alert doctors to the patient's mental capacity. With appropriate training of doctors, as students [3] and as junior practitioners [12], inter-professional culture, rather than be rejected, will be more acceptable and appreciable.

Institutional culture and support cannot be underestimated. An institution that is dominated by a certain group and drives towards specific targets will create unease in the environment between healthcare cadres [13]. Top-down regulations from managers in controlling care pathways in NHS create resistance among doctors

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[5]. Increasing awareness of these issues helped to root-analysis and change practice for patient benefit and better professional training. The most prominent logistic obstacle to organising MDT meetings is finding an appropriate time to bring all these people together as a team. In addition, appropriate location and equipment is necessary to hold effective group meetings.

A team depends on the commitment of its members and on effective leadership [14,15]. An MDT meeting's room should be prepared and equipped with necessary tools, such as necessary technology to check results or have easier and more reliable communications [14,15]. As pre and peri-meeting preparations are important as well the post-meetings. Patient-centred care, coordination, applying the meeting's decisions and involving patients/carers/family in the management plan, auditing the process and outcomes related to MDT working and meetings are also important for MDT to properly function [15].

Survey: The author of this paper obtained a sample of geriatricians' opinions on the current MDT meetings. The majority of the respondents are satisfied with regard the current model that led by consultant geriatricians. MDT meeting questions (Figure 1); 83.6% believe that the current clinicians' led MDT meeting in geriatric medicine is good and effective and, the general view from their comments is one of satisfaction with the current model.

Of the geriatricians, 69% are satisfied with the presence of one consultant and occasionally may require opinions from different specialties but, as reflected in some of the comments, this can be performed outside the MDT meeting setting. In addition, 74.5% of them are positive that their presence in other MDT meeting specialties is essential to improve patients' care and discharge planning, for example surgical branches, but this depends on the capacity of the departments for care of the elderly.

Positive views regarding the level of communication between health-cares allied in MDT meeting were given by 63.6%, with, noted from their comments, a lack of representatives from community health workers. The remaining issues in the geriatricians' views are the health-allied inconsistencies of attendees, especially among therapists at the senior level.

Of the geriatricians, 54.5% have access to a computer and the investigation results but it is regarded as unnecessary by many as all the results are expected to be in the notes prior the MDT meetings.

There is confirmation by 61% that patients' preference is mentioned and documented in the MDT meeting. Many confirm inconsistencies in this practice in their meetings. Eighty percent of the MDT meetings' decisions are documented in the notes (Figure 1: MDT meeting questions).

Geriatric Multidisciplinary Team Meetings

MDTs were established to bring together teams with special knowledge and expertise and to provide and maintain high standards of care to patients. These meetings require all members of the team, medical and allied healthcare professionals, to be present.

In these meetings the patient has to be considered as a whole, not just as a medical problem. The outcomes of MDT meetings, such as recommendations for care, have to be discussed with the patient or the carer before any decision (National Cancer Action Team, 2010).

Is the current MDT geriatric meeting model, which is mainly led by a consultant geriatrician, beneficial to the patients' care?

Yes No Comments

Do you think more than one consultant is necessary to participate in this meeting? (from same specialities, other team and/or from different specialities)?

Yes No Comments

Do you agree that geriatrician participation in other specialities' MDT meetings, such as psycho-geriatrics, palliative care and orthopaedics would improve patient care?

Yes No Comments

During the current MDT meetings, are you satisfied with the level of communication taking place between disciplines, in order to reach effective clinical decisions?

Yes No Comments

Do you have access to radiology, pathology results and other technical support during the MDT meetings?

Yes No Comments

Are patients' views, preferences and needs recorded during the course of their hospitalisation?

Yes No Comments

MDT discussions and outcomes, are they documented in the notes?

Yes No Comments

Figure 1: Questionnaire; Out of 335 consultants, 55 geriatricians participated in this survey; the response rate was 16.4%. Any skipped questions were regarded as undecided.

We can extrapolate from geriatricians' comments in the survey that geriatric MDT meetings are focused and facilitate communication of medical professionals with the rest of disciplines. Current geriatric MDT model escalate patients' discharges according to the pools of geriatricians' opinions. Generally, geriatricians do not see the advantage of inviting other specialists to their MDT meetings, but they are willing to participate with a positive view in other specialists' meetings, especially in the surgical departments.

The inter-departmental communication level is not acceptable, according to one-third of respondents, mainly due to inconsistence in attendance of senior-level therapists in the MDT meetings and infrequent attendance of social workers. Unavailability of modern technology is not an issue in their view in this survey and relies on update medical notes.

There is a defect in the documentation of patient preference and outcome of MDT meetings, as 20% of them do not document in their notes.

Conclusion

There is a consensus on the effectiveness of the current model in performing MDT Meetings in geriatric medicine. Those in liaison services are obliged to be involved in trans-departmental working groups meetings. It is important to mention that this survey conducted in 2011, since implementation of 7 days working and increasing demand on rapid process of patient flow most of geriatric units within NHS hospitals have already replace traditional MDT in to daily board round. Yet the concept of meeting and discipline gathering are much the same, hense this survey still has value in taking in account UK geriatricians in their MDT meetings.

References

1. Wilson V, Pirrie A (2000) Multidisciplinary team working indicators of good practice. The Scottish Council for Research in Education.
2. Ruhstaller T, Roe H, Thürlimann B (2006) The multidisciplinary meeting: an indispensable aid to communication between different specialities. European Journal of Cancer 42: 2459-2462.
3. Fronek P, Kendall M, Ungerer G (2009) Towards healthy professional-client relationships: The value of an interprofessional training course. Journal of interprofessional care 23: 16-29.
4. Thompson T (2003) Handbook of health communication. Routledge publication.
5. Amin K (2010) The medical profession and the state.
6. Trojan L, Suter E, Arthur N (2009) Evaluation framework for a multi-site practice-based interprofessional education intervention. Journal of interprofessional care 23: 380-389.
7. Walshe K (2003) Understanding and learning from organisational failure. Quality and Safety Health Care 12: 81-82.
8. Walshe K (2004) When things go wrong: How healthcare organisation deal with major failure. Health Affaire 23: 3.
9. Walshe K (2002) The use and impact of inquiries in the NHS. BMJ 325: 895-900.
10. Evans J (2007) Cultivating the habits of commonsense leadership. Academic Leadership Online Journal 1: 4.
11. Copnell G (2010) Modernising allied health professions careers: Attacking the foundations of the professions?. Journal of interprofessional care 21: 63-69.
12. Lidskog L, Lofmark A, and Ahlstrom G (2009) Learning through participating on an interprofessional training ward. Journal of interprofessional care 23: 486-497.
13. Morris Z (2005) Policy futures for UK health. Radcliffe press.
14. Cavanagh C (2010) National Cancer Action Team MDT Co-ordinator. Annual Conference.
15. Taylor C (2009) Results from a survey commissioned by the National Cancer Action Team. National Cancer Action Team MDT Development Programme report.