

# Multidisciplinary Team Meeting in Digestive Oncology: When Opinions Differ

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## Abstract

In daily oncology, Multidisciplinary Team (MDT) meetings are used worldwide to take every main decision. In order to improve the MDT efficiency, an analysis of decision-making process relying on patients refusing to undergo MDT proposal during presentations, in accordance with their referent specialist, was retrospectively performed in an academic and tertiary center, from 1995 to 2010. Out of 1000 patients, 0.5% refused the MDT proposal because of (1) ignorance of current evidence-based literature, (2) heterogeneous interpretations of the technical feasibility, and (3) the MDT undervaluing patient's specificities and wishes. In order to offset the MDT decision, patient needs to come from a well-off and educated background and to get the uttered support of the referent specialist. MDT conclusion is not customized because of interindividual exceptions and technical evaluations. Clinical Nurse Specialists attending to "blind" MDT meetings may help to back oncologic patient's specificities and wishes. *Clin Trans Sci* 2014; Volume 7: 319–323

**Keywords:** multidisciplinary team, oncology, decision-making process

## Introduction

In medicine, the physician must deal with the concept of "responsibility" on a daily basis. This "responsibility" is related to the patient, her disease, her wishes, the treatment, its results, and complications. Therefore, this concept of "responsibility" is complex and its limits are defined mainly in two different codes: Law and Ethics.

In France during the past decade, three changes in Law have modified the management of the patients in oncology. Starting with the so-called Kouchner Law in 2002,<sup>1</sup> the patient's informed consent is now compulsory for any procedure or investigation. In 2005, the Leonetti Law<sup>2</sup> has extended this obligation to the end-stage of lethal diseases, an addition allowing palliative patients to refuse care, and so, to avoid intensive medication. And finally, specifically in oncology, the "Plan Cancer"<sup>3</sup> is used since 2003. The "Plan Cancer" has been designed in order to legally standardize the management of oncologic patients. It defines the Multidisciplinary Team (MDT), its members, schedule, and quality requirements. Each patient suffering from a cancer must be presented at least once in order to assess the main line of the treatment. Most academic centers complied to the rules prior 2003, and the "Plan Cancer" release. Moreover, the MDT conclusions are advisory, and the responsibility belongs to the specialist presenting and representing her patient during the meeting.

MDT meetings are at the center of the decision-making process. Hopefully, in most cases, this process is easy: conclusions reach an evidence-based and consensual management in accordance with patient's wishes in a common oncological pathology. But the discussion may also outline multiple opinions: the MDT opinion, the specialist's opinion, and the patient's specificities and wishes. In these few cases, the concept of responsibility is complex while Law and Ethics may differ. Recently, discrepant decisions between the specialist and the MDT have been evaluated to reach 0.5–2% of MDT presentations.<sup>4,5</sup> These situations are not uncommon but still difficult to manage, with conflicts of interest. In the French system, the final decision belongs to the patient since the Kouchner Law

(2002), but the responsibility belongs to the referent specialist (or physician).

In this study, we aimed to retrospectively analyze the decision-making process in oncological MDT in order to identify the decision's underlying factors. Using these results, we hypothesize the reasons of disagreements, the potential lacks, the ethical issues, and possibly propose optional managements. Here we present the results.

## Material and Method

The study was retrospectively performed with one senior surgeon in the *Department of General and Digestive Surgery* of the Antoine Béchère Hospital, a tertiary and French academic centre of digestive and oncological surgery.

From January 1995 to June 2010, we recorded every patient suffering from a digestive cancer, and referred to the participating senior surgeon (considered as the specialist and the referent surgeon). Each patient was presented during MDT meetings and MDT reports were recorded. Patients who refused the MDT proposal and underwent an alternative treatment (the treatment suggested by the referent surgeon) were selected to compose the observational sample.

Patients from the observational sample were scrutinized. We recorded age, sociocultural, professional, and domestic details; medical notes including medical histories, MDT reports, alternative treatments, treatment outcomes, and the long-term results; the interview of the patients (or family) enabling to describe aims; and interviews of the referent surgeon, objectives, and feelings considering the disagreements.

## Results

From January 1995 to June 2010, the MDT meetings were scheduled each week. Every patient suffering from a digestive/abdominal cancer and referred to the department was presented during MDT meetings at least once and before any main decision (such as surgery or chemotherapy). The MDT was composed of

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DOI: 10.1111/cts.12164

Characteristics	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Age (years)	62	53	42	68	42
Gender	Male	Male	Female	Male	Male
Marital status	Married	Married	Married	Married	Married
Job	Retired manager in international firm	Sales and marketing person	CEO in a confectionery firm	Retired detective	Sales and marketing person
Disease	Gallbladder cancer with 5 hepatic metastases	Colorectal centro-hepatic metastasis	Colorectal hepatic metastases; vena cava involved	Gastric cancer with latero-aortic mass.	30 cm diameter Retro-peritoneal liposarcoma
MDT suggestion	No demonstrated benefit from surgery; chemotherapy	Unresectable. Chemotherapy	Unresectable hepatic lesion; chemotherapy	Palliative; chemotherapy	Unresectable. Chemotherapy
Patient's choice	Liver resections* after 12 months of effective chemotherapy	Hepatectomy (R0) <sup>†</sup> after colectomy and adjuvant chemotherapy	Hepatectomy (R0) <sup>‡</sup> with vena cava prosthetic reconstruction and adjuvant chemotherapy	Gastrectomy (R0) and tumorectomy and adjuvant chemotherapy	Surgical resection (R0) and adjuvant chemotherapy
Follow-up	5 years	3 years	17 years	2 years	2 years
	No recurrence	Pulmonary recurrences; deceased	No recurrence	Recurrences; deceased	Recurrences; deceased

\*Bisegmentectomy IV-V and 3 atypics wedge resections.

<sup>†</sup>Extended left hepatectomy (Couinaud's segments II-III-IV) and Bi-segmentectomy V-VIII.

<sup>‡</sup>Extended right hepatectomy (Couinaud's segments IV-V-VI-VII-VIII).

**Table 1.** Patients characteristics.

radiologists, oncologists, pathologists, gastroenterologists, and digestive surgeons from a single academic center (before and after the “Plan Cancer” release). Among digestive surgeons, four senior surgeons including two professors of surgery were reported: one of these professors is the referent surgeon contributing to the study. No Clinical Nurse Specialist (NCS) attended the meetings.

During the considered period, 1000 patients were referred to this surgeon and presented during MDT meetings. Five patients (out of 1000) refused the MDT proposal and decided to undergo another treatment, in accordance to the referent surgeon. These patients were scrutinized for the purpose of this study.

These five patients' characteristics are presented in the *Table 1*.

As reported, patients were adults (42, 42, 53, 62, and 68-year-old, respectively) from an educated and well-off background. Two patients were retired (patients 1 and 4). They were all married, with a stable home life, including two patients (patients 3 and 5) with young children. No psychiatric disorders were reported in past medical histories. They all displayed the wish to understand and to be involved in the decision-making process. The prognosis was shared with them at every step.

Patient 1 presented with a gallbladder cancer and five hepatic metastases. Treated initially with palliative chemotherapy, the objective response was exceptional for 20 months (symptom-free, increased weight [+8 kg], tumor markers divided by 500–1000 [CA19 9 and CEA], shrunk lesions on several consecutive CT scans). Specialized referral expected an imminent treatment failure. In spite of no demonstrated study in the scientific literature, the referent surgeon suggested to undergo surgical procedure which aimed to increase the patient's life-expectancy.

Patient 2 presented with a unique but 13 cm diameter colorectal liver metastasis, and the hepatic resection was discussed. In opposition to MDT opinion, the referent surgeon considered the feasibility of the surgical procedure and expected to switch

the treatment from palliative to curative. Knowing the risks, the patient consented to undergo surgical procedure.

Patient 3 presented with a colorectal liver metastasis involving the inferior vena cava and compressing hepatic veins. The risky but curative procedure (major liver resection and vena cava reconstruction) was decided with the patient. Her main aim was to raise her young daughters.

Patient 4 with a gastric cancer associated to a right-sided latero-aortic mass. In medical history, a resected right-sided spinal neurinoma was reported 15 years ago. The MDT interpreted the mass as a metastasis, and considered the patient was palliative (requiring only chemotherapy). The surgeon did not agree and perform the surgery in accordance with the patient. The gastrectomy and mass resection were performed, the mass being a neurinoma recurrence.

Patient 5 presented with a 30 cm diameter retroperitoneal liposarcoma without metastasis. The resection was discussed; the MDT concluded this lesion was unresectable because of vessels involvement. The surgeon evaluated the technical feasibility, and, in accordance with the patient, they decided to undergo surgical procedure. Vessels were not involved and the complete resection was performed.

All patients were referred to the surgeon as complex cases, requiring a second opinion. In each case, several presentations to MDT were performed. At some point, the referent surgeon disagreed with the MDT conclusions over the patients. These disagreements were related to (1) the lack of answer in the Evidence-Based Medicine for one patient (patient 1), (2) different interpretations of the technical feasibility in four cases (patients 2, 3, 4, and 5) and (3) the MDT opinion did not consider patient's specificities and wishes (patients 1, 2, 3, 4, and 5).

Considering the medical decision, the final word belonged to the patient: the referent surgeon exposed the MDT report,

the alternative treatment, and foreseeable outcomes and complications for each option. Every selected patient decided to undergo alternative option. They felt these treatments were adapted to their needs. Furthermore, all patients were considered palliative by the MDT, but underwent curative treatments. With at least 5 years of follow-up, two patients out of five are now cured.

Regarding the decision-making process, it resulted from force interaction.

Three main forces were identified:

- The *Emotional Force*. This force arose from patients' wishes and specificities. Therefore, it relied on personal history and personality. In our analysis, patients came from an educated background making them able to fully understand consequences and express their disagreement. No denial was observed, they were also fully involved in the medical decision. The *Emotional Force* was also consistently opposed to the MDT proposal as no patient accepted to be considered as palliative. Every patient agreed to undergo surgical procedure in spite of risks. Additionally, some patients expressed specific wishes, such as patient 2 who wanted a few of years' survival in order to raise her two daughters.
- The *Rational Force*, coming from the Multidisciplinary team. This force resides in the MDT proposal, the team decision during case presentation. Mainly related to patient's notes and scientific literature, this force is as objective as knowledge used to draw conclusions. As a collective force, the responsibility is softened.
- The *Human Force* is related to the referent specialist. As an active factor in her patient's treatment, as an advisor, with her own experience and believes, she plays the role of an interface between the MDT and the patient. Conflicts of interest were identified in the MDT (with other surgeons or specialists, considering the disagreements; with patients, considering the beliefs of the surgeon and the fear of isolation related to the refusal); the surgeon had to overcome these conflicts.

The Force Interaction leads mainly to negotiation and compromise. In the five studied cases, the *Rational Force* was opposed to the *Emotional Force* and the *Human Force*. In order to offset the *Rational Force*, the *Emotional Force* needed the *Human Force*, in spite of the Kouchner Law (and the protection of patient's will): the referent specialist support was necessary in order to comply with patients' wishes.

## Discussion

Changes in MDT meetings in France are intriguing and motivated this qualitative analysis in digestive oncology.

First, the studied specialty is an interesting field of study. MDTs specialized in digestive and oncological surgery debate a wide range of diseases and technical procedures. Decisions and technical evaluations are brainstorming.

Secondly, changes in the French legal system are interesting: since 2002, new laws and the "*Plan Cancer*" have entirely modified the decision-making process. These modifications have compelled specialists to schedule meetings and record conclusions. The Kouchner and Leonetti Laws have also given the decision-making power to the patient. This reversal might also be seen as paradoxical: those who are supposed to hold, and do the Knowledge do not take the decision. The negotiation between the physician and the patient comes from this statement. At the same time, Ethical concerns have not changed for the patients.

Finally, to our knowledge, no similar qualitative study based on such an amount of patients has been performed.

MDT meetings in oncology are currently at the center of attention and tools are developed in order to increase performances.<sup>6</sup> Indeed, their usefulness is demonstrated<sup>7,8</sup> in spite of being imperfect and arduous: 47.6–73% first case presentations<sup>9,10</sup> lead to a decision. Furthermore, this study could help to better understand the decision-making process in complex cases, and to improve medical and ethical outcomes; the analysis defined treatment as the result of force interactions (and their own conflicts of interest).

First, the *Rational Force* stands in the collective MDT. We described it as rational because established on collective decisions (with the strength of the majority), associated to a recognized knowledge: the scientific literature and its modern component, the Evidence-Based Medicine (EBM). In the modern era, Medicine needs to be seen as a science and relevant proofs are commonly required. Based on statistics, the EBM is the best approach for a high proportion of patients. But it also includes major defaults, especially because the statistics are not perfectly used in medical field<sup>11</sup> and mostly wrong when facing exceptions. Indeed, the EBM does not take into account the emotional, individual, exceptional and imaginative factors, sociocultural, and other immeasurable criteria. Beyond this internal mechanism, several conflicts of interest challenging the required dispassion exist: MDT hierarchy/requirements and individual factors. Furthermore, the *Rational Force* seems to act blindly.

Then, the *Emotional Force* resides in the patient, her choices and wishes, depending on the patient's personal history, beliefs and needs. In France, this force is supposed to be legally superior and should give to the patient the final word.

Finally, the *Human Force* is related to the referent specialist. With experience, imagination and adaptability, the specialist plays the role of an interface between the MDT and the patient, as a translator and advisor. Furthermore, she has to show the will to be an active factor, with her own beliefs as a subjective individual. From an ethical point of view (also legal in France), she is responsible for her patients. This statement may lead to deep conflicts of interest, particularly if she manifests some disagreement to the MDT during meetings, as demonstrated in our analysis.

Considering the results of the study, changes in law did not impact MDT outcomes or the referent surgeon: in this tertiary academic center, requirements related to the "*Plan Cancer*" were already fulfilled (at least one meeting every two weeks, three attending specialists, and at least one obligatory presentation for each patient presenting with a cancer), and considering Kouchner and Leonetti Laws, the referent surgeon was already collecting consents of informed patients prior these laws were published. Patients we identified as undergoing treatment in accordance with the referent surgeon and despite MDT conclusions reached roughly 0.5% of cases presented during MDT meetings. In the scientific literature, failure to implement MDT conclusions because of patients refusal are reported to reach 2–5.1% of decisions.<sup>4,9,12</sup> The association of a patient and his referent specialist as being opposed to the MDT conclusions seems to be rarer: these unconsensual cases reach 0.5% to 2%<sup>4,5</sup> in the literature. In view of the study, three terms must coexist to result in disagreement.

First, patients who refused MDT conclusions were assessed as palliative (without any hope for a curative treatment) by the MDT.

Secondly, these patients had a wealthy and educated background. Because the MDT judged them as palliative, this

profile may have pushed to look for (and so open up) alternative options. These conclusions are in accordance with previous publications<sup>13</sup> and may be a hot topic in the French idea of a free and equal healthcare.

And finally, an obvious and formulated disagreement between the referent surgeon/specialist and the MDT was required. In literature, 85% of doctors have disagreed with the final MDT decision in an important way at some time, but only 29% did formally dissent.<sup>14</sup> Reason for disagreement is not described in literature; in our report, the lack of consensus was related to the technical aspect of the treatment (which was differently appraised) or from a circumstances not described in guidelines.

Considering the *Force Interaction*, these three conditions led to oppositions: the *Rational Force* (seeing the patient as palliative) was opposed to the *Human Force* (considering the patient is not palliative and can benefit from a surgical procedure) and the *Emotional Force* (the patient refusing to be considered as palliative and expressing personal choices). As the opposition between the MDT and wishes was complete, the compromise was difficult to reach and MDT decision-making process became inadequate; the *Emotional Force* (related to the patient's wish and choices) and the *Human Force* (related to the specialist's experience and adaptability) against the *Rational Force* (the MDT). The MDT may have failed to adapt to the patient's specificities and wishes as it has already been reported.<sup>15-18</sup> This inability to adjust is the main criticism as it does not take in account exceptional features. It is also unfortunate MDTs answer is more suited to common (and so easy) medical histories.

Two adjustments may help to solve identified ethical gaps.

In France, CNSs' influence is still underrated, as the first educational program was opened in 2009. Yet, they could play a primary role during MDT meetings like in United Kingdom.

As previously demonstrated, CNSs have answered to the psychosocial lack during MDT meetings<sup>19-22</sup> to make heard patients' voice. They have also increased the MDT performances.<sup>23</sup> In France and since legal changes, Clinical Nurse Specialists should attend to MDT meetings in order to back responsible specialists and patient's wishes. Therefore, programs should be developed in order to educate CNS, and to make their role and aims known to the medical teams.

"Blind meetings" may be an additional option. Indeed, a case presentation to a MDT not related to the patient, having information about referent specialist's suggestion but not knowing who is the specialist, with the Clinical Nurse Specialist attending the meeting, could help to partially avoid conflicts of interest. However, the Clinical Nurse Specialist who met the patient should attend to this blind meeting as the only individual knowing the patient, her specificities and wishes, in order to respect them.

Considering this study, some issues are worth a commentary.

The small sample is a limitation in order to draw conclusions. Indeed, the proportion of refusal (0.5%) in our study is in accordance with previous publications.<sup>4,5</sup> So, in order to increase the quality of the study, we decided to perform a situational analysis, with interviews, and to describe the force interaction in the decision-making process. To the best of our knowledge, it is the first time this kind of analysis is performed.

In France, responsibility belongs to the referent specialist for her patient's health but, as noticed, the decision belongs to the patient. Considering MDTs, a proposal which does not fit to

the patient can not be seen as the best option, especially if the law gives the last word to the patient. Of course patients' wishes must reach realistic positions, and take into account the medical and collective issues. Afterwards, the responsibility belongs to the referent specialist; the necessity to name a person in charge implies that underlying risks exist. In our study, we reported a single specialist in accordance with his patients undergoing an innovative and customized but unconventional (and so possibly riskier) treatment. We think these risks should be assumed by the MDT, hazardous proposals should come from the community, and MDTs' role mainly stands in complex decisions. However, consequences, benefits and complications, like decisions, still are held by the patient. Assuming the patient accepts her decisions and their risks, restrictions of the proposed treatment (and so the patient's decision and the related risks) may be wondered. Moreover, limits to the treatment have been defined in the Declaration of Helsinki for Human Medical Experimentation.<sup>24</sup> Consenting individuals allow empirical treatments to be performed under strict considerations. Whatever reasons push them to participate in, we can compare the consent to experimentation with the patient's will to undergo a specific (but realistic) treatment. These managements are the basis of medical advances.

The decision-making process during MDT in oncology needs adjustments in order to fit to Ethics and to patient exceptions. When some points will be debated endlessly (technical feasibility, lack of scientific evidence in some fields), influence of conflicts of interest, and disrespect for patient's specificities and wishes are major concerns. Furthermore, MDT improvements will lead to individual and collective hopes: as MDT conclusions fit to patients, the medical progress benefits greatly from patients decisions and the necessity to push the limits. Hope in Medicine and Imagination as an Engine.

### Grant Support

None.

### Disclosure

No funding has been received for this work from any of the following organizations: National Institutes of Health (NIH); Wellcome Trust; Howard Hughes Medical Institute (HHMI); and other(s).

### Conflict of Interest

The authors have no conflict of interest to declare.

### Author Contributions

Alban Zarzavadjian Le Bian: conception and design, interpretation of data, revising it critically for important intellectual content, final approval of the version to be published.

Renato Costi: revising it critically for important intellectual content

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Christian Herve: conception and design, interpretation of data, revising it critically for important intellectual content, final approval of the version to be published.

Claude Smadja: conception and design, interpretation of data, revising it critically for important intellectual content, final approval of the version to be published.



## References

1. LOI n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé. *Journal Officiel de la République Française*. 2002; 4118.
2. LOI n° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie. *Journal Officiel de la République Française*. 2005; 7089.
3. Décret n° 2003-418 du 7 mai 2003 portant création d'une mission interministérielle pour la lutte contre le cancer. *Journal Officiel de la République Française*. 2003; 8007.
4. Wood JJ, Metcalfe C, Paes A, Sylvester P, Durdey P, Thomas MG, Blazeby JM. An evaluation of treatment decisions at a colorectal cancer multi-disciplinary team. *Colorectal Dis*. 2008; 10: 769–772.
5. Orgerie MB, Duchange N, Pélicier N, Chapet S, Dorval E, Rosset P, Lemarié E, Hervé C, Moutel G. Decision process in oncology: the importance of multidisciplinary meeting. *Bull Cancer*. 2010; 97: 255–264.
6. Taylor C, Atkins L, Richardson A, Tarrant R, Ramirez AJ. Measuring the quality of MDT working: an observational approach. *BMC Cancer*. 2012; 12: 202.
7. Guillem P, Bolla M, Courby S, Descotes JL, Laramas M, Moro-Sibilot D. Multidisciplinary team meetings in cancerology: setting priorities for improvement. *Bull Cancer*. 2011; 98: 989–998.
8. Fleissig AJ, Jenkins V, Catt S, Fallowfield L. Multidisciplinary teams in cancer care: are they effective in the UK? *Lancet Oncol*. 2006; 7: 935–943.
9. Leo F, Venissac N, Poudenx M, Otto J, Mouroux J; Grouped Oncologie. Multidisciplinary management of lung cancer: how to test its efficacy? *J Thorac Oncol*. 2007; 2: 69–72.
10. Stalfors J, Lundberg C, Westin T. Quality assessment of a multidisciplinary tumour meeting for patients with head and neck cancer. *Acta Otolaryngol (Stockh)*. 2007; 127: 82–87.
11. Wang R, Lagakos SW, Ware JH, Hunter DJ, Drazen JM. Statistics in medicine—reporting of subgroup analyses in clinical trials. *N Engl J Med*. 2007; 357: 2189–2194.
12. Blazeby JM, Wilson L, Metcalfe C, Nicklin J, English R, Donovan JL. Analysis of clinical decision-making in multi-disciplinary cancer teams. *Ann Oncol*. 2006; 17: 457–460.
13. Lamb BW, Brown KF, Nagpal K, Vincent C, Green JS, Sevdalis N. Quality of care management decisions by multidisciplinary cancer teams: a systematic review. *Ann Surg Oncol*. 2011; 18: 2116–2125.
14. Sidhom M, Poulsen M. Group decisions in oncology: doctors' perceptions of the legal responsibilities arising from multidisciplinary meetings. *J Med Imag Radiat Oncol*. 2008; 52: 287–292.
15. Penel N, Grosjean J, Pichon-Watelle F, Giscard S, Hoppe H, Taieb S, Vanseymortier L, Adenis A. Factors favouring palliative treatment multidisciplinary decisions for newly diagnosed visceral and soft tissue sarcomas. *Clin Oncol*. 2008; 20: 523–527.
16. Clarke MG, Wilson JR, Kennedy KP, MacDonagh RP. Clinical judgment analysis of the parameters used by consultant urologists in the management of prostate cancer. *J Urol*. 2007; 178: 98–102.
17. Wilson J, Kennedy K, Ewings P, Macdonagh R. Analysis of consultant decision-making in the management of prostate cancer. *Prostate Cancer Prostatic Dis*. 2008; 11: 288–293.
18. Langenhoff BS, Krabbe PF, Ruers TJ. Computer-based decision making in medicine: a model for surgery of colorectal liver metastases. *Eur J Surg Oncol*. 2007; 33: S111–S117.
19. Junnola T, Eriksson E, Salanterä S, Lauri S. Nurses' decision-making in collecting information for the assessment of patients' nursing problems. *J Clin Nurs*. 2002; 11: 186–196.
20. Kidger J, Murdoch J, Donovan JL, Blazeby JM. Clinical decision-making in a multidisciplinary gynaecological cancer team: a qualitative study. *BJOG*. 2009; 116: 511–517.
21. Amir Z, Scully J, Borrill C. The professional role of breast cancer nurses in multi-disciplinary breast cancer care teams. *Eur J Oncol Nurs*. 2004; 8: 306–314.
22. Lancelley A, Savage J, Menon U, Jacobs I. Influences on multidisciplinary team decision-making. *Int J Gynecol Cancer*. 2008; 18: 215–222.
23. Haward R, Amir Z, Borrill C, Dawson J, Scully J, West M, Sainsbury R. Breast cancer teams: the impact of constitution, new cancer workload, and methods of operation on their effectiveness. *Br J Cancer*. 2003; 89: 15–22.
24. Rickham PP. Human Experimentation. Code of Ethics of world medical association. Declaration of Helsinki. *Br Med J*. 1964; 2: 177.