BRITISH JOURNAL OF HOSPITAL MEDICINE

EDITORIAL

Leadership and Chairing Styles in Cancer Multidisciplinary Teams: Balancing Collaboration and Efficiency

Tayana Soukup[1,*], Louisa Hardman[2], Ellen Quinney[3], Benjamin W. Lamb[4,5,6]

[1]Department of Surgery and Cancer, Faculty of Medicine, Imperial College London, London, UK
[2]Living Potential Consulting, London, UK
[3]NHS North East London Cancer Alliance, London, UK
[4]Department of Urology, Barts Health NHS Trust, London, UK
[5]Barts Cancer Institute, Queen Mary University of London, London, UK
[6]Department of Urology, University College London Hospitals NHS Foundation Trust, London, UK
*Correspondence: t.soukup@ic.ac.uk (Tayana Soukup)

Abstract

Multidisciplinary teams (MDTs) and their meetings are central to cancer care and other chronic conditions: promoting treatment standardization, reducing geographical variability, and improving patient outcomes. However, increasing complexity, workload pressures, and resource constraints require effective leadership and chairing. Leadership sets strategic goals, shapes team culture, and drives long-term improvement, while chairing ensures operational efficiency through structured and efficient discussions. These complementary roles demand adaptive styles to balance inclusivity and efficiency within and beyond meetings. Transformational and facilitative leadership inspire innovation and collaboration, while directive approaches help maintain focus in high-pressure contexts. Human factors, including cognitive fatigue and authority gradients, influence MDT dynamics, highlighting the need for workflow optimization, shared responsibilities, and fatigue management. Equally important is empowering followers through training in communication and collaborative skills, which further mitigates power imbalances. By aligning chairing and leadership styles with meeting demands and integrating supportive technologies, MDTs can sustain their pivotal role in patient-centred care and achieve both strategic and operational success in cancer treatment planning.

Key words: delivery of health care; interdisciplinary communication; leadership; decision making; patient care planning; fatigue

Submitted: 3 December 2024 Revised: 4 February 2025 Accepted: 6 February 2025

Introduction

While this editorial primarily focuses on cancer care, the principles of leadership and chairing discussed herein apply to any specialty that uses the multidisciplinary (MDT) model, including cardiology, neurology, and orthopaedics. The challenges of coordinating complex cases, managing team dynamics, and balancing leadership roles are common across all MDT settings.

Over the past three decades, MDTs have become the cornerstone of cancer care, reducing variability, and improving patient outcomes (Calman and Hine, 1995; Kesson et al, 2012; Lamb et al, 2011; Soukup et al, 2023). Rooted in reforms from the Calman and Hine (1995) and mandated by the Improving Outcomes Guidance

How to cite this article:
Soukup T, Hardman L, Quinney E, Lamb BW. Leadership and Chairing Styles in Cancer Multidisciplinary Teams: Balancing Collaboration and Efficiency. Br J Hosp Med. 2025. https://doi.org/10.12968/hmed.2024.0976

(NICE, 2019), MDT discussions are mandatory in the UK, promoting adherence to best practices and supporting timely diagnostics and treatments (NICE, 2019). Beyond clinical benefits, MDTs are perceived to contribute toward healthcare professional wellbeing, education, and quality assurance (Taylor and Ramirez, 2004), with their success extending to other chronic conditions (NICE, 2019).

However, as MDTs have evolved, they face mounting challenges. Rising cancer incidence, survival rates, treatment options, and comorbidities strain resources (Soukup et al, 2019a,b, 2018). Over-reliance on MDT discussions for all cases, including straightforward ones, has compounded this burden and created inefficiencies (Hoinville et al, 2019). National efforts (Cancer Research UK, 2017; Darzi, 2024; Gore, 2017) have examined strategies to optimise MDT function, highlighting resource alignment, greater efficiency, and refined roles (Hoinville et al, 2019).

Leadership and chairing styles in MDT meetings serve both strategic and operational purposes (Weller et al, 2014). While leadership shapes the overarching vision, driving culture and long-term improvements through innovation and motivation (Edmondson, 2012; Heifetz et al, 2009), chairing focuses on practical management, structuring meetings, ensuring inclusivity, and guiding informed decisions (Kauffeld and Lehmann-Willenbrock, 2012). Leaders (often surgeons, oncologists, or radiologists) balance team culture with operational efficiency, focusing on collaboration, quality improvement, and care planning (Lamb et al, 2011; Taylor and Ramirez, 2004). Chairs typically oversee 40–60 cases within 1–4 hours with their MDT, requiring focus, time efficiency, addressing cognitive fatigue, and balancing inputs for effective case reviews (Hoinville et al, 2019; Lamb et al, 2011). Followers play a vital role by contributing specialised expertise, engaging in discussions, and improvement initiatives, while supporting both leadership and chairing efforts to ensure inclusivity and comprehensive care planning (Alanazi et al, 2023).

Leadership and Chairing Styles

Table 1 shows different leadership and chairing styles have strengths and limitations (Gottfredson and Aguinis, 2017). Transformational leadership inspires innovation and motivation, but risks overlooking immediate needs (Bass and Riggio, 2006). Facilitative and democratic styles encourage collaboration and inclusivity, yet may slow progress (Gastil, 1994; Woods, 2004). Directive and autocratic approaches allow swift decisions in emergencies, but can suppress input (Gottfredson and Aguinis, 2017). Laissez-faire empowers proactive teams but can lead to disorganisation if members are less driven (Skogstad et al, 2007), while micromanagement maintains control at the cost of morale and autonomy (White, 2010). Transactional leadership handles routine tasks effectively but may limit innovation and long-term vision (Bass and Riggio, 2006). Balancing these styles is essential for building an effective, patient-centred MDT (Braithwaite et al, 2017).

While leadership focuses on shaping team culture and aligning broader objectives (Heifetz et al, 2009), chairing emphasises practical aspects of individual meetings, such as structuring discussions and synthesising diverse perspectives (Kauffeld and Lehmann-Willenbrock, 2012). Both require adaptive methods to engage

Table 1. Leadership and chairing styles with overlaps, strengths and weaknesses.

Style	Description	Applies to leadership	Applies to chairing	Strengths	Weaknesses
Transformational	Inspires team members with a vision for long-term goals and continuous improvement, focusing on motivation and innovation.	✓	✗	Encourages innovation, team motivation, and patient-centred care.	May overlook immediate practicalities and focus too much on big-picture goals.
Facilitative	Empowers team members to contribute equally and collaboratively. Ensures all voices are heard and consensus is built. Applies to both chairing and leadership, fostering inclusivity during meetings and collaborative culture beyond.	✓	✓	Promotes teamwork, balanced participation, and conflict resolution.	Can be slower and less efficient if overly focused on team process.
Democratic	Involves the team in decision-making and seeks consensus. Encourages team input during meetings, while retaining authority to make the final decision if needed. Promotes shared decision-making in both meetings and long-term team initiatives, balancing operational and strategic goals.	✓	✓	Ensures inclusiveness and diverse perspectives. Builds trust and team engagement.	May slow down decision-making, if overly focused on consensus, especially in urgent situations.
Directive	Controls the flow of the meeting, enforces the agenda, and ensures time management. Used to maintain focus and efficiency in meetings.	✗	✓	Provides clarity and structure, efficient in high-pressure situations	Limited team input, stifles creativity, not ideal for long-term
Autocratic	Exercises tight control over decisions, with minimal input from the team. Makes unilateral decisions and limits discussion. Applies to both chairing and leadership, ensuring efficiency during meetings and decisive action in high-pressure situations, but potentially suppressing team input and innovation.	✓	✓	Efficient in emergencies, quick decision-making.	Suppresses team input, reducing engagement and innovation.

Table 1. Continued.

Style	Description	Applies to leadership	Applies to chairing	Strengths	Weaknesses
Laissez-faire	Provides little guidance or direction, allowing the team to self-manage. Takes a hands-off approach, which can lead to disorganized meetings. Applies to both chairing and leadership, empowering highly skilled and self-sufficient teams to function independently, but risking inefficiency and lack of structure in less proactive teams.	✓	✓	Gives freedom to highly skilled teams to function independently.	Can lead to disorganization and missed decisions if the team lacks initiative.
Micro-management	Overly controls every detail of team operations, stifling autonomy. Primarily applies to leadership when team members are micromanaged continuously.	✓	✗	Ensures tasks are done as expected.	Demoralizes team members, stifles creativity and innovation.
Transactional	Focuses on structured tasks, rewards, and penalties to achieve specific goals. Primarily used for managing routine, task-oriented aspects of leadership.	✓	✗	Good for routine tasks and meeting specific objectives.	May hinder creativity and long-term thinking.

team members and maintain focus (Heifetz et al, 2009). For example, leaders might use transformational or democratic styles to unify the team around shared goals (Bass and Riggio, 2006), while chairs employ similar techniques to ensure inclusive and efficient discussions (Kauffeld and Lehmann-Willenbrock, 2012). By combining strategic leadership with operationally sound chairing, MDTs can pursue long-term quality improvements while ensuring each meeting contributes meaningfully to broader objectives (Edmondson, 2012; Weller et al, 2014). This integration enables outcomes that are both practical and visionary, reinforcing the MDT's role in high-quality, patient-centred care (Braithwaite et al, 2017).

Human Factors Impacts

Human factors significantly influence MDT performance and decision quality (Soukup et al, 2019a,b, 2020a,b; Weller et al, 2014). Chairs often face dual-task interference-juggling clinical inputs, decision-making pressures, and leadership duties-creating a cognitive load that can weaken coordination and compromise decision-making (Soukup et al, 2016). Emphasising shared responsibility through a facilitative style helps reduce the burdens (Heifetz et al, 2009).

Prolonged meetings exacerbate these challenges (Soukup et al, 2019a,b). Cognitive fatigue can erode decision-making and team contributions, leading to shortcuts that undermine thorough case review (Soukup et al, 2019b, 2020a,b). Logistical barriers, such as equipment malfunctions and administrative errors, further disrupt meeting flow (Cancer Research UK, 2017; Soukup et al, 2020a). One study found that logistical problems affected over 42% of MDT cases, contributing more to decision-making variance than clinical complexity (Soukup et al, 2020a).

Power dynamics, including hierarchical structures and professional "tribalism", can also undermine decision-making. Adopting transformational and facilitative behaviours encourage diverse input, mitigates authority gradients, and facilitates an inclusive environment. Leaders can use transformational approaches to inspire broad engagement, while chairs promote equal input, and followers engage collaboratively to prevent dominance by any one group (Alanazi et al, 2023).

Following are examples of human factors impact team dynamics:

- Teamwork: Hierarchy and varying expertise can hinder collaboration (Weller et al, 2014), leading to fragmented discussions and missed opportunities (Lamb et al, 2011). Facilitating open participation can counter authority gradients (Edmondson, 2012).
- Communication: Miscommunication risks incomplete or inaccurate recommendations (Kauffeld and Lehmann-Willenbrock, 2012). Active listening, clear data presentation, and structured turn-taking improve decision-making (Soukup et al, 2016).
- Authority gradients and power dynamics: Senior voices can overshadow junior input (Gore, 2017). Leaders can address hierarchy systematically (Heifetz et al, 2009), while chairs can ensure balanced participation in meetings; and followers ask clarifying questions to prevent any group from dominating (Alanazi et al, 2023).

- Cognitive load and fatigue: High case volume, complexity and meeting length increase cognitive load, leading to errors and reduced participation (Soukup et al, 2019a). Scheduling breaks and limiting cases per meeting can mitigate fatigue (Hoinville et al, 2019; Soukup et al, 2019b).
- Workload and time pressures: Large caseloads and tight deadlines may rush discussions, limiting exploration of complex cases (Soukup et al, 2020a). Streamlining workflows and prioritizing cases can improve discussion quality (Soukup et al, 2023).

Practical Recommendations for MDT Leadership and Chairing

Effective MDT leadership and chairing require a dual focus: operational strategies to enhance meeting management and strategic approaches to address broader team dynamics and quality improvement initiatives. Effective MDT leadership requires the strategic application of leadership styles tailored to the unique challenges of MDT meetings (Heifetz et al, 2009; Weller et al, 2014). Transformational and facilitative styles facilitate an inclusive culture, encouraging high-level discussions and long-term innovation (Bass and Riggio, 2006; Edmondson, 2012). However, in high-pressure situations or when managing a large caseload, directive and autocratic approaches may be necessary to maintain efficiency/timely decision-making (Gottfredson and Aguinis, 2017; Skogstad et al, 2007). Balancing these styles is crucial for both operational and strategic success (Braithwaite et al, 2017; Heifetz et al, 2009).

Additionally, chairs need to remain adaptable, shifting between facilitative and directive styles as meeting progresses (Heifetz et al, 2009). Early in meetings, facilitation encourages diverse contributions (Kauffeld and Lehmann-Willenbrock, 2012), while later more directive approach can keep discussions on track (Edmondson, 2012). By responding to the team's needs, chairs ensure that discussions are productive and align with patient-centred goals (Weller et al, 2014). Leaders, meanwhile, may use transformational styles for long-term goals or more directive approach when swift action is required. Followers also play a crucial role by contributing specialised knowledge, collaborating, and supporting both leadership and chairing roles (Alanazi et al, 2023).

For instance, when a complex cancer case is being discussed, a chair might adopt a transformational style to motivate the team to think innovatively about treatment options. In contrast, during the final decision-making phase of the meeting, the chair might switch to a directive style to ensure that decisions are made promptly. Followers may use collaborative behaviours, offering their insights and supporting the chair in managing the discussion (Alanazi et al, 2023).

Many of the strategies described in Table 2 apply equally to MDTs managing other chronic conditions where MDTs are involved. These strategies are grouped into operational (meeting-focused) and strategic (beyond meetings) approaches to clarify their scope and application.

Table 2. Key strategies for effective multidisciplinary team (MDT) functioning.

Strategy	Example
Operational strategy (in meeting)	
1. Streamline workflows and prioritise cases	Focus MDT meetings on complex cases, delegating simpler or non-critical cases to alternative pathways. This reduces unnecessary workload, ensuring discussions remain efficient and meaningful (Hoinville et al, 2019; Soukup et al, 2023).
2. Utilise technology	Automate administrative tasks and integrate digital tools to streamline data access, enabling chairs to focus on facilitating discussions (Cancer Research UK, 2017; Gore, 2017). A transformational leadership approach ensures that these technologies support patient-centred care rather than dictating decision-making (Bass and Riggio, 2006).
3. Adapt leadership styles during meetings	Transition between facilitative and directive approaches as meetings progress. A facilitative style at the start encourages diverse contributions (Kauffeld and Lehmann-Willenbrock, 2012), while a directive approach later ensures focus and resolves discussions efficiently as fatigue sets in (Edmondson, 2012; Soukup et al, 2019a).
4. Rotate chairing responsibilities	Sharing chairing duties prevents decision fatigue and reduces the cognitive load on any one individual (Soukup et al, 2019a). Rotating roles across meetings can also foster engagement and build confidence among team members (Edmondson, 2012).
5. Mitigate cognitive fatigue	Incorporate scheduled breaks and refreshments into lengthy MDT meetings to sustain attention and maintain discussion quality (Soukup et al, 2019b). Proactively managing fatigue ensures consistent engagement throughout the meeting.
6. Encourage proactive contribution from followers	Followers should be prepared to share specialized knowledge, raise clarifying questions, and volunteer for tasks. This supports chairs in managing discussions and ensures all relevant perspectives are considered, maintaining a balanced decision-making process (Alanazi et al, 2023).
Strategic strategies (beyond meetings)	
1. Invest in leadership development	Provide training programmes that equip chairs and MDT leads with strategies to manage dominant voices, ensure balanced participation, and foster a collaborative environment (Heifetz et al, 2009; Weller et al, 2014). Structured participation guidelines, such as checklists, can help mitigate hierarchical barriers and encourage inclusivity (Taylor and Ramirez, 2004).

Table 2. Continued.

Strategy	Example
2. Regularly review processes	Periodically evaluate meeting structures, workflows, and logistical arrangements to identify recurring challenges and implement improvements (Pillay et al, 2016). Continuous assessment ensures MDTs remain adaptable and aligned with evolving goals.
3. Separate the roles of meeting chair and MDT strategic lead	This distinction builds on the complementary nature of leadership and chairing, as discussed, ensuring that chairs can focus on immediate meeting efficiency while leaders address overarching goals and team development. Effectively allocating time for MDT activities in healthcare professionals' job plans is essential. While MDT chairs often have allocated time to attend meetings, MDT leads require time for leadership activities such as case preparation, audit, and quality improvement. Where redundancy exists within a specialty, MDT leads may selectively attend or chair meetings, using the extra time for strategic improvement efforts.
4. Prioritise selection and recruitment of chairs and leads	The appointment of chairs and leads should not default to the longest-serving member. Instead, candidates with an appetite for leadership and a clear understanding of the complexities of MDT management should be prioritised. This ensures effective, motivated leadership that aligns with the evolving demands of MDTs.
5. Provide professional development for followers	Encourage followers to attend workshops or training on active listening, conflict resolution, and assertiveness (Alanazi et al, 2023). Empowered, well-trained followers enhance collaborative dynamics and help maintain inclusive, high-quality decision-making.

Lastly, the behaviours essential for effective leadership, chairing, and followship in MDTs can be cultivated through targeted training. Programs for leaders and chairs should develop transformational and facilitative skills that help manage team dynamics, navigate authority gradients, and foster inclusivity. In parallel, training for followers can strengthen communication and collaborative abilities—such as active listening and conflict resolution—ensuring they feel empowered to contribute effectively. For example, a novel Leadership and Chairing Development Programme within the Northeast London Cancer Alliance focuses on these core skills, helping address power dynamics and enhance MDT efficiency.

By embedding such training in routine MDT practices, healthcare systems promote continuous improvement in leadership, chairing, and collaboration. This balanced approach, which combines adaptive leadership styles, operational meeting management, and proactive strategies for human factors, ensures MDTs remain responsive to evolving demands and continue delivering high-quality, patient-centred care (Braithwaite et al, 2017; Soukup et al, 2018).

Key Points

- The MDT model of care is the cornerstone of cancer care and other chronic conditions, with leadership and chairing principles applied across specialties.
- Increasing MDT workload complexity requires adaptive leadership and effective chairing to balance operational efficiency with collaboration and inclusive decision-making.
- MDT roles (leaders, chairs, followers) need tailored leadership and chairing behaviours: leaders inspire innovation and set vision; chairs ensure efficient, structured meetings; followers contribute collaboratively to team cohesion.
- Behaviour styles, including transformational, facilitative, democratic, and directive, can be applied by leaders, chairs, and followers depending on the situation, fostering effective decision-making and MDT functioning.
- Power dynamics (hierarchies and tribalism) affect all MDT members; inclusive leadership and balanced participation from leaders, chairs, and followers help manage these dynamics.
- Leadership and chairing behaviours can be developed through training.
- A collaborative MDT culture is enhanced through leadership development initiatives, engaging all members in delivering high-quality, patient-centred care.

Availability of Data and Materials

Not applicable.

Author Contributions

TS, LH, EQ, and BWL contributed substantially to the conception and design of the work. TS drafted the manuscript. TS, LH, EQ, and BWL critically revised the manuscript for important intellectual content. All authors contributed to the interpretation of data and the development of the editorial content. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of its accuracy and integrity.

Ethics Approval and Consent to Participate

Not applicable.

Acknowledgement

Not applicable.

Funding

Infrastructure support for TS was provided by the NIHR HealthTech Research Centre in In-Vitro Diagnostics (London, UK).

Conflict of Interest

BWL and TS received funding from Cancer Alliances and NHS England for training MDTs in assessment and quality improvement methods in the United Kingdom; and honoraria for public speaking from Parsek. TS received consultancy fees from Roche Diagnostics, Parsek and Salutare. BWL received consultancy fees from Digital Surgery Ltd, MDOUTLOOK; and honoraria from Astra Zeneca and Astellas. LH is an employee of Living Potential Consulting. EQ declares no conflict of interest.

References

Alanazi S, Wiechula R, Foley D. Followership in health care clinicians: a scoping review. JBI Evidence Synthesis. 2023; 21: 1764–1793. https://doi.org/10.11124/JBIES-22-00310

Bass BM, Riggio RE. Transformational leadership. 2nd edn. Psychology Press: UK. 2006.

Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell G. Association between organisational and workplace cultures, and patient outcomes: systematic review. BMJ Open. 2017; 7: e017708. https://doi.org/10.1136/bmjopen-2017-017708

Calman K, Hine D. A policy framework for commissioning cancer services. Department of Health: London, United Kingdom. 1995.

Cancer Research UK. Improving the effectiveness of multidisciplinary team meetings in cancer services. 2017. Available at: https://www.cancerresearchuk.org/about-us/we-develop-policy/our-policy-on-cancer-services/improving-the-effectiveness-of-mdts-in-cancer-services (Accessed: 2 January 2025).

Darzi A. Independent investigation of the NHS in England. Department of Health and Social Care: UK. 2024.

Edmondson AC. Teaming: How organizations learn, innovate, and compete in the knowledge economy. John Wiley & Sons: USA. 2012.

Gastil J. A definition and illustration of democratic leadership. Human Relations. 1994; 47: 953–975. https://doi.org/10.1177/001872679404700805

Gore M. Transforming Multidisciplinary Team Meetings (MDTMs). 2017. Available at: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/10/Transforming-MDTM-Martin-Gore-August-2017.pdf (Accessed: 2 January 2025).

Gottfredson RK, Aguinis H. Leadership behaviors and follower performance: Deductive and inductive examination of theoretical rationales and underlying mechanisms. Journal of Organizational Behavior. 2017; 38: 558–591. https://doi.org/10.1002/job.2152

Heifetz R, Grashow A, Linsky M. The practice of adaptive leadership: Tools and tactics for changing your organization and the world. Harvard Business Press: USA. 2009.

Hoinville L, Taylor C, Zasada M, Warner R, Pottle E, Green J. Improving the effectiveness of cancer multidisciplinary team meetings: analysis of a national survey of MDT members' opinions about streamlining patient discussions. BMJ Open Quality. 2019; 8: e000631. https://doi.org/10.1136/bmjoq-2019-000631

Kauffeld S, Lehmann-Willenbrock N. Meetings matter: Effects of team meetings on team and organizational success. Small Group Research. 2012; 43: 130–158. https://doi.org/10.1177/1046496411429599

Kesson EM, Allardice GM, George WD, Burns HJG, Morrison DS. Effects of multidisciplinary team working on breast cancer survival: retrospective, comparative, interventional cohort study of 13 722 women. BMJ (Clinical Research Ed.). 2012; 344: e2718. https://doi.org/10.1136/bmj.e2718

Lamb BW, Brown KF, Nagpal K, Vincent C, Green JSA, Sevdalis N. Quality of care management decisions by multidisciplinary cancer teams: a systematic review. Annals of Surgical Oncology. 2011; 18: 2116–2125. https://doi.org/10.1245/s10434-011-1675-6

National Institute for Health and Care Excellence (NICE). Improving outcomes guidance. 2019. Available at: https://www.nice.org.uk (Accessed: 2 January 2025).

Pillay B, Wootten AC, Crowe H, Corcoran N, Tran B, Bowden P, et al. The impact of multidisciplinary team meetings on patient assessment, management and outcomes in oncology settings: A systematic review of the literature. Cancer Treatment Reviews. 2016; 42: 56–72. https://doi.org/10.1016/j.ctrv.2015.11.007

Skogstad A, Einarsen S, Torsheim T, Aasland MS, Hetland H. The destructiveness of laissez-faire leadership behavior. Journal of Occupational Health Psychology. 2007; 12: 80–92. https://doi.org/10.1037/1076-8998.12.1.80

Soukup T, Gandamihardja TAK, McInerney S, Green JSA, Sevdalis N. Do multidisciplinary cancer care teams suffer decision-making fatigue: an observational, longitudinal team improvement study. BMJ Open. 2019a; 9: e027303. https://doi.org/10.1136/bmjopen-2018-027303

Soukup T, Lamb BW, Arora S, Darzi A, Sevdalis N, Green JS. Successful strategies in implementing a multidisciplinary team working in the care of patients with cancer: an overview and synthesis of the available literature. Journal of Multidisciplinary Healthcare. 2018; 11: 49–61. https://doi.org/10.2147/JMDH.S117945

Soukup T, Lamb BW, Morbi A, Shah NJ, Bali A, Asher V, et al. A multicentre cross-sectional observational study of cancer multidisciplinary teams: Analysis of team decision making. Cancer Medicine. 2020a; 9: 7083–7099. https://doi.org/10.1002/cam4.3366

Soukup T, Lamb BW, Shah NJ, Morbi A, BaliA, Asher V, et al. Relationships between communication, time pressure, workload, task complexity, logistical issues, and group composition in transdisciplinary teams: A prospective observational study across 822 cancer cases. Frontiers in Communication. 2020b; 5: 583294. https://doi.org/10.3389/fcomm.2020.583294

Soukup T, Lamb BW, Weigl M, Green JSA, Sevdalis N. An Integrated Literature Review of Time-on-Task Effects With a Pragmatic Framework for Understanding and Improving Decision-Making in Multidisciplinary Oncology Team Meetings. Frontiers in Psychology. 2019b; 10: 1245. https://doi.org/10.3389/fpsyg.2019.01245

Soukup T, Petrides KV, Lamb BW, Sarkar S, Arora S, Shah S, et al. The anatomy of clinical decision-making in multidisciplinary cancer meetings: A cross-sectional observational study of teams in a natural context. Medicine. 2016; 95: e3885. https://doi.org/10.1097/MD.0000000000003885

Soukup T, Stewart GD, Lamb BW. Defining an evidence-based strategy for streamlining cancer multidisciplinary team meetings. The Lancet. Oncology. 2023; 24: 1061–1063. https://doi.org/10.1016/S1470-

2045(23)00440-0

Taylor C, Ramirez AJ. Multidisciplinary team members' views about MDT working: Results from a survey commissioned by the National Cancer Action Team. London: NHS National Cancer Action Team. 2009. Available at: https://doczz.net/doc/8252940/multidisciplinary-team-members–views-about-mdt-working- (Accessed: 2 January 2025).

Weller J, Boyd M, Cumin D. Teams, tribes and patient safety: overcoming barriers to effective teamwork in healthcare. Postgraduate Medical Journal. 2014; 90: 149–154. https://doi.org/10.1136/postgradmedj-2012-131168

White RD. The Micromanagement Disease: Symptoms, Diagnosis, and Cure. Public Personnel Management. 2010; 39: 71–76. https://doi.org/10.1177/009102601003900105

Woods PA. Democratic leadership: Drawing distinctions with distributed leadership. International Journal of Leadership in Education. 2004; 7: 3–26. https://doi.org/10.1080/1360312032000154522