

Tumor talk: A descriptive study of communication about tumor board meetings

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ABSTRACT

Tumor board meetings are behind-the-scenes settings where communication about health and strategizing about healthcare delivery take place. Despite their wide use in hospitals and cancer centers, there is a dearth of information about the communication practices in this context. Drawing upon six weeks of observations, this study investigated communication during tumor board meetings at a tertiary cancer center in the South-eastern United States. Findings revealed differences in communication among cancer specialties, with one tumor board consistently talking about the medical and non-medical elements of patient cases, while other specialties focused primarily on plans for treatment with little discussion about quality of life, economic, or caregiver support issues. The manuscript includes suggestions for modifying tumor conferences and opportunities for future research.

Introduction

In 2020, cancer was among the leading causes of death worldwide.¹ According to the World Health Organization (2022), proper diagnosis is essential, and appropriate care considers the type of cancer, the goals of the person being treated, and their quality of life. Social science research about cancer care tends to focus on interactions that occur between doctors and patients in clinical settings, such as the doctor's office. Communication scholar Laura Ellingson² noted that cancer care involves many behind-the-scenes interactions among nurses, dietitians, social workers, genetic counselors, physician's assistants, radiologists, and oncologists. While previous scholars²⁻⁴ have conducted research about healthcare teams, little research has focused on interactions that occur in one behind-the-scenes setting called a "tumor board" (also sometimes called a "tumor conference").

Tumor board meetings convene several experts from the hospital setting or a sub-specialty of care (e.g., head and neck cancer or lung cancer) to discuss unique cancer cases. Some tumor boards are interdisciplinary (e.g., similar disciplines, but different foci) and others are multidisciplinary (e.g., social workers, dietitians, oncologists), and their goals can vary. These clinicians consider patient cases focusing on a course of treatment. For example, an oncologist who specializes in caring for older adults may have a patient with an aggressive form of skin cancer, but

because her expertise centers on recommending chemotherapy or radiation treatment rather than surgery, she may seek the advice of the cutaneous (skin) tumor conference to determine if surgery is an option. Experts in this patient's type of cancer, or with the surgical skills, will discuss the feasibility of offering this patient surgery during a weekly tumor conference.

I first became aware of tumor boards while attending these weekly meetings in an effort to recruit participants for a study of terminally ill head and neck cancer patients.⁵ Our efforts to recruit using these meetings was largely unsuccessful. Patients were not described as terminally ill by clinicians, and topics that would indicate declining health, such as futility of treatment or poor quality of life, were not discussed either. After and between these sessions, we started asking ourselves and each other what was the point of tumor boards. My curiosity sent me to the literature where I found tumor conferences had gone unexplored by social scientists despite an emphasis on the role of effective communication in cancer care, patient-centered care, and increased use of teams in healthcare.

Tumor board meetings attempt to address the knowledge or skills limitations, or gaps physicians may have due to specialization, with the goal of positively influencing patient care.^{6,7} These meetings also contribute to physician education, foster review of cancer management practices, and help keep practitioners informed about ongoing clinical trials which are especially relevant at cancer centers.⁶ Tumor board meetings offer opportunities for cross-disciplinary communication believed to encourage best practices and outcomes for patients. Judi McCaffrey, a board certified otolaryngology surgical oncologist, noted that these meetings should also aid in minimizing the “god complex” by providing a setting where peers can freely challenge treatment plans, especially if care may be futile (McCaffrey, 2011, personal communication). Research on the efficacy of tumor conferences seems mixed. Petty and Vetto⁸ called into question the quality, function, and benefits of tumor board meetings, particularly as they relate to patient care. Similarly, Keating and colleagues⁹ indicated that tumor boards have little effect on the quality of care for cancer patients.¹⁰ One prospective study, however, focused on whether or not tumor boards influenced treatment plans and found the sessions had efficacy.¹¹ In an umbrella review of tumor conferences, researchers found that these meetings were the best way to deliver complex cancer care;¹² however, they went on to note that more research is needed to evaluate tumor boards' role in other issues such as quality of life and patient satisfaction. Wheelless, McKinney, & Zanation focused on the influence of communication on patients' treatment plans, yet did not focus on quality or nature of talk itself as a mechanism for understanding cancer care or outcomes.¹¹ While the literature is not definitive about the value and efficacy of tumor board, use of tumor boards persists. It is important to note, however, that these studies generally do not examine tumor boards in real time to in-

vestigate communication as it occurs, but instead, rely on chart reviews and survey data.

According to Ellingson, “documentation and explication of existing communication practices on [healthcare] teams will help generate strategies for improving communication within and outside of teams” (p. 7).³ Weston and colleagues have also noted the benefits of observations in healthcare contexts, asserting that this method allows for understanding behaviors in context, while identifying opportunities for intervention and improvement.¹³ Given the importance of team observation in a clinical setting, an observational study describing and analyzing communication during tumor conferences is an important first step for developing more specific research questions that can aid with additional qualitative research as well as hypothesis development. Therefore, this study sought to address the following research questions:

RQ 1: What is the nature and content of communication during tumor board meetings?

RQ 2: To what extent does the communication during tumor board meetings include non-biomedical considerations?

Materials and Methods

To address the research questions, all site-specific specializations with tumor boards (approximately 10) at a tertiary cancer center in the Southeastern United States were contacted about the study and invited to participate. I began observing and taking fieldnotes during tumor boards for three of the 10 specializations—breast, cutaneous (skin), and blood and bone marrow cancer—after receiving approval from both the cancer center's ethics committee and my university's Institutional Review Board. During my initial attendance at a tumor board, I described my study, secured informed consent from participants, and allowed attendees to ask questions about the study's goals and methods. I did not announce my attendance at subsequent meetings, but I did seek consent from attendees as needed. Anyone who did not sign a consent form did not have their communication recorded in fieldnotes. No identifying information was included in any fieldnotes, and any agendas or patient lists that I received during the meetings were deposited in secured bins at the research site at the conclusion of each meeting. Weekly tumor board meetings lasted, on average, ninety minutes to two hours (but some as long as four hours), and 15-50 patient cases (per tumor board) were discussed each week. Cases presented during blood and bone marrow meetings were fewer (approximately 12 cases a week), but the meetings could last as long as four hours. Breast and cutaneous tumor board meetings presented more patients (30-50 cases), but never lasted more than two hours. Data collection lasted six weeks (42 hours), and 460 patient cases were reviewed during these sessions.

Differences between the three tumor boards became evident early in the data collection process. The difference between blood and bone marrow tumor board and the breast and cutaneous meetings were evident after the first week of observations. Throughout the data collection process, I asked myself why these differences existed and why they were so stark. I also discussed the differences with another communication scholar familiar with tumor board meetings as well as two physicians from the blood and bone marrow clinic. After the conclusion of data collection, when I felt confident additional observations would yield no new findings, I looked back at all of the data with the goal of identifying any categories or themes, adopting Morse's¹⁴ distinctions where categories consist of a collection of similar data and themes include an "essence" that runs through the data. Analysis led to categories, but not themes. The findings include categories about the general content and structure of the meetings and about novel and difficult patients. I begin with a description of the physical meeting spaces and the structure of the meetings, followed by analysis of patterns regarding communication about patients.

Results

Distinctions between breast and cutaneous clinics and the blood and bone marrow clinics were noticeable during the first week of data collection. The quality of communication and content of discussions differed, and the physical meeting spaces, including the location and set up of the rooms, were markedly different as well. In what follows, I describe a typical gathering of the breast and cutaneous tumor boards, and then go on to discuss the content of communication about patients and their plans of care, followed by discussion of the blood and bone marrow tumor board meetings.

Physical space and layout of breast and cutaneous meetings

The breast and skin cancer tumor boards meet in the same conference room with seating for approximately 60 people. At the front of the room is a screen, computer station, and a projector like that of a document camera. The room is dimly lit, bordering on dark, with small microphones hanging delicately from the ceiling. Tables are set up in rows and at the tables sit people in scrubs and white lab coats: surgical oncologists, radiation oncologists, medical oncologists, and nurses. Surgeons, who are also often the treating physicians, sit in the front of the room, filling the first two rows. Medical and radiation oncologists sit behind them, followed by nurses. In the remaining rows are other specializations (e.g., a dietitian, a genetic counselor, and a social worker) and visitors from other clinics wearing a mix of lab coats and business casual attire. On the left side of the room is a counter with

coffee and bagels during the breast cancer tumor board, which meets Tuesdays at 7:30 a.m., and pizza or sandwiches during the cutaneous meeting, which meets on Wednesdays at noon. During some meetings, a pharmaceutical representative is positioned by the food and greets staff members as they help themselves to refreshments.

Structure of meetings during breast and cutaneous meetings

All attendees receive a list of patients on the agenda, and the breast and cutaneous meetings begin with a pathology report from a radiologist. This includes viewing slides of the cancer cells providing information about a patient's tumor based upon biopsies or resections. During this portion of the meeting, the radiologist provides information about the type of cancer, the stage (I-IV), and if the biopsy margins are clean, indicating whether or not the resection of the cancer was completed with surgery. Occasionally, the treating physician, usually the surgical oncologist, will ask a clarifying question of the radiologist. The radiologist's reports last approximately 20 minutes, and after the review is complete the radiologist leaves. From that point the agenda turns to multidisciplinary review.

Patient demographic information along with diagnosis and treatment (if started) is available on the agenda, and patient reviews follow in the order listed. Patient information is not orally presented consistently; attendees follow these reports with occasional guidance from the director of the tumor board about which patient is up next for discussion.

This portion of the meeting also includes screening of images, such as CT or PET scans. The display of a scan showing an advanced cancer will often prompt an audible response from the breast cancer tumor board attendees. Similarly, during the cutaneous tumor board, photographic images of skin cancer lesions garnered audible gasps. Outside of these reactions, the audience is quiet. While the image is on view, a report will begin. The following are examples of typical reports from the skin cancer meeting:

Patient was on hospice at 46 because he needed a kidney transplant, now has mets [metastatic] disease, refused biopsy. Patient not a candidate for anesthesia [for biopsy of scalp lesion and some lesions around the eye].

Patient has untreated lung cancer, 8cm mushroom tumor, recommend radiation therapy, will probably lose right eye, but patient has cataracts in left eye so he may not be able to see.

The following is a typical report from breast cancer meeting:

Very healthy 93-year-old, lumpectomy only, don't think she is appropriate for radiation.

These two tumor boards have very similar processes and approaches, and they stand in stark contrast to the blood and bone marrow tumor boards, as described below.

Physical space and layout of blood and bone marrow meetings

Blood and bone marrow tumor conferences occur on Friday afternoons in a small and brightly lit conference room with one large table and executive style office chairs. The room does not have any visible technology or recording equipment. Clinic staff all sit at the same table, with physicians often congregating near each other. Unlike the other two tumor board meetings, my presence is more obvious in this space. The clinical staff wear business attire with no obvious signs that they are medical professionals. The participants greet each other and chat as they await the arrival of the other clinicians. An agenda is distributed, and reports occur as follows:

51, unrelated donor. Day plus 55 [person is 55 days from donation]. There is some concern about the caregiver [who is the patient's ex-wife] being burned out and not sleeping. [Someone described her as a saint.] Patient only there eight days, but the issue seems to be that she [the caregiver] was frustrated about meds, that the patient may not be taking them and was stressed, but she is totally committed to caring for the patient. Patient is worsening.

Patient won't make it to donation.

66, professor of theater from another state. He will need to find an outside donor because his brother has multiple health issues including diabetes and cannot donate. Brother has an interesting history, was a sniper in the military and had been shot several times. [Reporting physician goes on to talk more about the patient's brother's personal story.]

42, wife noticed swelling in the patient's neck, and he had a tonsillectomy. Surgeon discovered a tumor, and patient was referred to cancer center. He also has bone lesions which are unusual. There is a five-year survival rate with therapy and had a partial relapse. He's got good family support, young, and no comorbidities, so they are going to pursue treatment.

If another physician or nurse cared for one of the patients being reported on, they may also offer additional observations about family relations, a patient's mood, or their medical status. As a result, some meetings lasted as long as four hours.

Novel and difficult patients

Detailed patient reports during a breast or cutaneous tumor board meeting similar to those described above

from the blood and bone marrow tumor board were rare. A closer examination of fieldnotes found that reports during breast or cutaneous tumor boards that did include more personal details centered on what I have labeled as "novel" or "difficult" patients. Reports about caregivers or home situations were not standard practice during breast and skin cancer tumor boards, but did occasionally occur under extreme, unusual, or difficult treatment scenarios. The following is an example from the cutaneous tumor board:

Axillary dissection of a six mm tumor with extra cap extension. The man weighs 350 lbs., had surgery, and is still draining 100 CCs of fluid a day.

Following this report, the treating physician and the radiation oncologist discuss the patient further, and I captured the nature of the conversation in a summary note:

How he heals will determine whether or not he is able to receive radiation according to the rad onc [radiation oncologist]. The doctor described this as a "sad case" with social issues, saying that the patient lost his job, his house, and his wife all in the same year. Patient has no insurance, and so there's some question about what type of treatment he can receive. He also lives outside of the city proper, so treatment every other day may not be clear/possible. He can get PEG [a type of treatment] without insurance. "He's still working and has no insurance?" asks an audience member. "It's America," was the physician's response.

This is an example of a novel patient because the non-medical facts of their case were introduced as being unique or atypical. Commentary about the case followed. A second instance of when description was offered occurred during a breast tumor conference when the patient was difficult or non-compliant:

Patient is "31 going on 12." She has a palpable mass, and surgery is recommended, but an MRI is needed. I suggested she get off of birth control, and the patient said she didn't think she could do that. So, I had to have my sex education talk with her. She wants to continue to party. She came back for the MRI and reported that she couldn't have it done because she thought she might be pregnant. I think she is putting off care. We can't do re-incision with the type of surgery that was previously performed. Patient has a family history with aunt [diagnosed] at the age of 41.

Frustration expressed by the reporting physician was palpable. Following this report, a different physician suggested that this patient could stay on oral contraception

and that this would help determine her cycle for other scans and procedures. No other support or recommendations were offered from the members of the gallery.

These examples address RQ1 which focused on the nature and content of communication during tumor board meetings. Communication during skin and breast cancer tumor boards largely focused on information exchange and the facts of the patients' cases, from the opening reports by the radiologist to the treating physicians' reports. Blood and bone marrow conferences included sharing information as well, but with a greater focus on the whole patient and their support systems (physical, social, and emotional). This indicates that non-biomedical issues are a standard topic of discussion during blood and bone marrow meetings. The second research question, which asks about the extent of non-biomedical considerations, begins to come into partial focus.

The above examples of novel or difficult patients from the breast and skin tumor boards were rare. They stand out from what are otherwise rote reports during breast and cutaneous tumor boards, which typically focus only on the medical facts of each case. The frequency and scope of talk about non-biomedical factors during these tumor boards center on those patients who present with social, financial, or emotional challenges to a physician's recommended plan of care. These findings raise several questions about the goals of tumor boards, present avenues for modifying communication during these sessions, and contribute to our understanding of talk during these meetings, thus suggesting several fruitful opportunities for additional research.

Discussion

The examples from the blood and bone marrow tumor board meetings, when compared to the breast and cutaneous conferences, illustrate a much greater emphasis on a patient's story beyond the medical facts of their case. There are several possible explanations for these differences. Blood and bone marrow cancer treatment is often inherently relational. Live human donors are frequently needed for patients to receive transplants, and these donors are often family; therefore, physicians will discuss the presence, absence, or complications (such as identifying a donor), and patients' related care. For instance, patients who receive a transplant are required to have a caregiver to assist them post-transplant, and some patients must remain hospitalized if they do not have a designated caregiver. When a patient does have a caregiver, that person must undergo training provided by the cancer center prior to the patient's discharge. Physicians described patients' family relationships for the purpose of identifying donors and suitable caregivers, but also discussed the home environments of patients. To ensure a successful transplant, patients require a sterile environment and are encouraged to refrain from engaging in behaviors or environments that could compro-

mise the success of the transplant. A patient with several cats, for example, was not able to return home for recovery following the transplant procedure, and patients who refused to quit smoking or refrain from alcohol were less likely to receive a transplant.

The presence or absence of a caregiver and living situations were not mentioned with cutaneous and breast cancer patients even though their treatments are time consuming (e.g., multiple weeks of daily radiation), and related side effects are often debilitating. Consider the patient above with the eight centimeter mushroom tumor who might lose their eye if they accept the recommended radiation therapy: no discussion ensued during the conference about how the team might problem solve or support the patient, including making a referral to other disciplines (e.g., social work or spiritual care) or services. More details about a patient were offered only when their case included some novel element or if the patient was resistant to the proposed plan of care. This is not to say that all patients who might be described as novel or non-compliant were highlighted during these meetings, but these elements were present when detailed reports occurred.

Information sharing over discussion

This study used real-time observations of tumor conferences to describe and understand the nature of communication during these weekly meetings. Information sharing among clinic staff to help fellow practitioners—should they encounter patients in their clinics or on rounds—is a key objective of tumor board meetings. Another objective is to ensure that physicians are not overtreating their patients, and only recently have cancer centers experimented with tumor boards with the explicit focus on a significant barrier to care: a patient's financial well-being.¹⁵ Little to no discussion about overtreating, however, was observed during this study. The majority of tumor board meetings (across all specialties) were, however, dedicated to information sharing. The quality or nature of the information depended upon the cancer specialty.

In cutaneous and breast cancer tumor boards, discussion focused primarily on the facts of the case, most of which were already described in the patient list/agenda. Talk centered on answering the question "Can we do this treatment?" rather than "Should we do this treatment?" When the treating physicians explicitly asked for input from their peers, they presented their plan for care and then looked to their peers to affirm the plan. This mechanism of reporting did not facilitate a discussion, but rather appeared to lead to passive agreement. Put another way, the format would require a member of the clinic staff to openly and publicly challenge the plan of care presented by their colleague. And since the presentations of patients only focused on the medical facts of the case, there was limited information for others in the clinic to work with. As a result, a treating physician's request for input about a course of treatment rarely triggered discussion, debate, or dissent.

Medical oncologists, whose primary mode of care is chemotherapy, and radiation oncologists who offer radiation treatment, would take these moments to suggest the possibility of providing their respective treatment modalities. Interestingly, despite the presence of nurses, dietitians, and social workers, these members of the board did not automatically report on cases as one might expect on a multidisciplinary team, unless they were invited to contribute, as was the case when a genetic counselor on the breast cancer tumor board was called on twice over six weeks to offer information about patient cases. Similarly, nurses would provide a detail from a patient's file only upon request from the physician they worked with. It thus appeared that the non-physician staff were in attendance primarily as passive participants to receive information. Although nurses were observed working on laptops during tumor board, the nature of that work was not clear or if it was related to tumor board.

In contrast, the blood and bone marrow tumor board provided information about patients beyond the medical facts of their cases. Issues of a patient's economic status, home environment, and caregiver support were discussed with more consistency. There was also more discussion among attendees at the blood and bone marrow meetings. This is most evident in the length of the meetings where members discussed fewer patients over a longer period of time. While the type of treatment explicitly warrants attention to such issues, the same issues are also present among patients with other sites or types of cancer. In other words, the illness experience is not limited to diagnosis or treatment, but includes quality of life issues, coping, identity changes, stigma, financial burdens, and time constraints, but this seemed to go unacknowledged in some tumor board meetings despite the relevance to health outcomes.¹¹ Of course, based upon the tumor board alone it is difficult to know if or how treating physicians incorporate non-medical issues into their medical practice and delivery of care. The lack of talk about these issues to all clinic staff during tumor board meetings, however, implicitly equates the patients with their illness rather than recognizing them as a whole person.

The use of photos, images, and scans

Since multidisciplinary review is one reason for presenting a patient's case at tumor boards, more frequent presentations of atypical cases were expected. This data, however, suggests that such cases may be infrequent. For example, scans and photographs can contribute to understanding a patient as novel. While the goal of tumor boards is to contribute to the ongoing education of team members, the use of photos in particularly unique or rare cases makes sense. The use of these images only when they are exceptions raises questions about the ability of photographs to humanize patients or garner compassion. If a novel or difficult patient case were accompanied by an image or scan, they could run the risk of stigmatizing

or degrading a patient, especially if the patient case is only presented with medical facts.

Content and quality of information

The content and quality of communication during blood and bone marrow cancer tumor boards stands in stark contrast to the breast and cutaneous tumor boards. The quality of information was richer and more narrative-based as the treating physicians described patients' diagnoses alongside information about their social, familial, and financial status. A patient report that failed to include this type of non-biomedical information was the exception and frequently occurred when a patient was close to discharge or would not receive treatment.

There are several possible explanations for why these differences exist. For instance, in addition to the treatment modality, the number of patients who undergo review during a blood and bone marrow tumor board is often less than half of the number of patients discussed during the breast and cutaneous meetings.

In contrast, discussing anything more than biomedical issues during breast and cutaneous tumor boards could be prohibitively time consuming. Much of the diagnostic and treatment information about a patient's case is already available on the list of patients scheduled for discussion. Rather than repeating this information, foregrounding quality of life issues or the reasons a patient might resist or fail to comply with recommended treatment regimens could better leverage the expertise of the multidisciplinary team.

Room layout

Clinics invested in the contributions of all disciplines should consider the set-up of the physical space and format of the meeting to invite participation. A different member of the clinic, such a nurse, social worker, or genetic counselor who has interacted with a patient could initiate the report followed by the treating physician. Changes could also be made to the seating arrangement at cutaneous and breast cancer conferences to reduce the perception of power differences and facilitate discussion across disciplines or ranks. Ultimately, facilitating communication across the members of the clinic can help fully realize the multidisciplinary purpose of the tumor board.

Limitations and future research

This study was a first step in describing communication during tumor board meetings; however, the number of tumor boards and a single research site are limitations. A larger number of tumor conferences, especially at more than one cancer center, would further clarify if the communication patterns described here is indicative of the culture at this cancer center, *per se*, or representative of tumor board more generally. Another challenge relates to the

method. Transcripts of these meetings, rather than field-notes, would allow for more precise analysis of communication, including such factors as language use and turn taking. Although this study did not set out to prove what type of communication might influence patient care and outcomes, it does suggest that a study which specifically examines such communication could prove fruitful by helping us understand: What types of appeals foster treatment changes? What is the outcome of patient care when issues of medical futility are raised by peers? And should questions about futility be standardized?

In a study about the presence of a family caregivers at interdisciplinary hospice team meetings, researchers found the nature and content of communication did in fact change in ways that could be relevant for tumor board operation.¹⁶ Would the presence of the patient or their representative, such a family member or friend, shift the discussion? Does the nature of communication change when attendees see patients' faces? What other socio-emotional issues important to patients should be considered during meetings? How would communication change if the physical space and seating at tumor boards were flipped? Would more disciplines participate if they were responsible for reporting about patients first? How would communication change if the driving question during tumor boards centered on patients' goals for care rather than the feasibility of care? More study of communication during these meetings would likely generate other questions about healthcare teams in general and cancer care specifically.

Conclusions

According to Blayney,¹⁰ the long history of the tumor board suggests the sessions will not end any time soon. As such, tumor boards will continue to be a fruitful site for study by qualitative researchers who want to understand healthcare teams' role in patient care.

More specifically, some cancer centers are beginning to recognize the potential value of considering non-medical issues, such as financial challenges, during tumor boards.¹⁵ While finances are not healthcare, as a social determinant of health, they do have a significant influence on a patient's ability to access care and follow through on the treatment plans that are carefully crafted by oncologists. This new focus is particularly important if, as previous research has indicated, these meetings have little positive influence on patient outcomes.

Altering the goals and improving tumor board practice is important if clinicians want to maximize care. This study described communication during tumor board con-

ferences to better understand the form and function of talk and offers suggestions for future study. Great strides have been made in treating cancer, but more work can be done towards caring for the whole person. Tumor boards are one site for positively contributing to comprehensive care.

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