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Analysis of the challenges faced by collegial support meetings at large cancer centre 10 years on: a qualitative study

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Title: Analysis of the challenges faced by collegial support meetings at large cancer centre 10 years on: a qualitative study

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Abstract:

Background: With scientific advances and the expansion of the range of treatments available in oncology, clinical situations are becoming more complexes. In light of these challenges, supervisory authorities recommended developing formalized Collegial Support Meetings for complex cases (CSMs). Despite of it, the institutionalization of these meetings remains difficult to implement as seen in a large Parisian cancer centre, where variable and fluctuating staff engagement has been observed 10 years after their implementation. Unlike multidisciplinary meetings, which have been thoroughly researched and have proven their effectiveness in terms of patient care and survival, there are limited data available in the literature investigating these programmes, their effectiveness, and the challenges they face. The aim of the current study was to explore and compare the perceptions and experiences of healthcare professionals (HCPs) with regards to CSMs.

Methods: We present here qualitative results derived from a thematic analysis of interviews conducted with 20 HCPs (senior physicians, residents, nurses, nursing assistants, psychologists, social workers) at the largest european cancer centre in Paris. These interviews focused on participants' opinions regarding participation in CSMs.

Results: CSMs were perceived as a decision-making tool promoting multidisciplinarity, mutual understanding, and decision support, thereby contributing to learning and to a sense of belonging. The main identified limitations related to the absence of the referring physician, organizational aspects and time constraints, as well as an ambiguity regarding the ultimate place of decision-making. CSMs could also be experienced as spaces of institutional judgement, likely to reproduce hierarchies or tensions, which were attenuated in emergencies situations.

Conclusion: Several prospects for improving this system are discussed like a organisational and temporal perspectives and the opportunity to involve patients more directly with a view to improving the shared decision making process. CSMs constitute a relevant yet improvable programme to enhance quality of care and to improve the well-being of HCPs' at work.

Key words:

collegial support meeting, ethics, decision making, shared decision making, cancer, multidisciplinary meetings, oncology, right care

Introduction

With scientific advances and the expansion of the range of treatments available in oncology, life expectancy is increasing and clinical situations are becoming more complex [1]. Questions arise throughout the course of treatment, particularly at the end of life, when unreasonable obstinacy becomes a central topic of discussion [2]. Patient care therefore requires multidisciplinary expertise and effective communication between all specialists in order to develop optimal treatment strategies [3]. Beyond professional collegiality, decision-making in healthcare should ideally involve the patient themselves. With this in mind, shared decision-making (SDM) is generally promoted as a favoured model for preference-sensitive decisions across many health care settings internationally [4], and it has been described as a key element

of person-centred care [5,6]. It provides an essential framework for combining multidisciplinary expertise with the preferences of patients and their loved ones, and is based on structured communication in order to jointly develop the care pathway.

In order to address these issues, multidisciplinary meetings (MDMs) are widely implemented in cancer centres [7]. Indeed, MDMs are increasingly seen as the optimum model of care for patients with cancer and offer a means to improve communication, coordination, and decision-making among healthcare professionals (HCPs) when weighing treatment options expressed by the patients [8,9]. Nevertheless, most conventional decision-making systems have room for improvement. Some, for example, involve only part of the healthcare team [7], which has been shown to undermine the quality of decision-making and the resolution of ethical conflicts[10–15].

In light of these challenges, in 2014, the preliminary report to the third French National Cancer Plan (Vernant) recommended developing formalised cross-disciplinary meetings for complex cases, in addition to traditional MDMs [16,17]. In line with this, in 2015, our French cancer centre set up Collegial Support Meetings (CSMs), which are part of a contemporary move towards collective governance in oncology, seeking to improve collegial decision-making and reduce suffering at work among HCPs by actively involving them in the reflection and decision-making process [18]. The CSMs comprise of oncologists as well as other professionals (nurses, nursing staff, etc.), a member of the palliative care team, an intensive care unit physician, and a psychologist [18]. The situations examined are proposed by the HCPs themselves. During CSMs, four major themes are regularly addressed (1) the intensity of oncological treatments, (2) therapeutic engagement in case of deterioration (intensive care, surgery, etc.), (3) optimisation of supportive care, (4) the patient's future orientation (Rehabilitation Care, Home Hospitalisation, Palliative Care Unit, intensive care unit...)[18].

Despite supervisory recommendations, the institutionalisation of these meetings as a standard of care remains difficult to implement [19]. Moreover, these programmes are not standardised and there are limited data available in the literature investigating these programmes, their effectiveness, and the challenges they face [7]. For instance, variable and fluctuating staff engagement has been observed over the past 10 years.

Gaining insight into the understanding of the challenges accompanying these CSMs may support an adjustment of their operating modalities in order to better meet the needs of complex clinical situations, to improve decision-making and institutional mechanisms and to allow their

large-scale replication. To this end, a qualitative study appears the most relevant, in order to explore HCPs' subjective representations on this matter. We therefore propose a thematic analysis of HCPs' discourse concerning the CSMs.

Material and Methods

Population

Inclusion criteria were: (a) to work as a HCPs (or social worker) i.e., nursing assistant, nurse, nurse manager, social worker, psychologist, physician (resident, chief resident/university assistant–hospital assistant, or senior physician); and (b) to have provided consent to be interviewed as part of this study. Exclusion criterion was insufficient command of the French language to participate in the study.

The study population consisted of 20 HCPs from the largest European cancer centre near Paris. The principle of thematic data saturation was used to finalize data collection [20]. Nevertheless, in view of the plurality and diversity of professional positions, data interpretation was only stopped when at least one person from each professional group had been interviewed (physician, nurse manager, nurse, and nursing assistant) according to the concept of the 'power of information', which supersedes the concept of thematic saturation [20]. This in at least two departments where CSMs are conducted frequently and two where they are not conducted, as well as when at least one participant from each supportive care professional group participating in CSMs had been interviewed (ethics committee member, psychiatrist, psychologist, social worker).

Given the sensitive nature of the issues addressed and the small sample size, we chose not to describe precisely the role of each participant in the present article to ensure keeping anonymity.

Study design

A descriptive qualitative study using thematic analysis was conducted. Indeed, a qualitative methodology fully addresses an exploratory objective and makes it possible to probe in depth participants' opinions, viewpoints, and disagreements [21]. The method used to ensure the reliability and validity of the results was guided by the Consolidated Criteria for Reporting

Qualitative Research (COREQ 33) checklist, which was also used to guide the project [23,24](Appendix 1).

The qualitative interviews were conducted in person by one psychiatrist (MH). MH is a female MD. Through her clinical work at this cancer centre, the researcher may have had pre-existing professional relationships with participants. It should be noted that it had previously been planned that a second researcher (VB), a psychiatry external student. This article was the subject of her thesis that MH supervised. VB had no connection with the participants, would also conduct the interviews with MH in the focus groups. However, the focus groups initially planned could not be carried out (the reasons for this are discussed in the Results section). As a result, all interviews were conducted by MH on site for logistic sake.

The semi-directed interview prompt was developed by drawing on previous literature and based on MH's knowledge of this system. The interview used was developed for this study. It was as follows:

-What do you think about CSMs?

-In your view, what is the usefulness of CSMs for the patient?

-What is the usefulness of CSMs for yourself?

-Which improvements would you suggest?

-What other forums do you use to discuss complex clinical situations or potential ethical dilemmas?

-From 0 to 10 (10 being maximum satisfaction), what score would you give to CSMs?

Empathetic follow-up prompts or open-ended questions were used to explore further participants' responses in a non-directive manner.

The prompt was developed by MH and VB and submitted to a third researcher (LF). LF is a female professor in psychology, a clinical psychologist in the same cancer-care centre and an expert in qualitative methodology. The guide was piloted with one HCP.

Contact and recruitment

The invitation to take part in the study via recorded interviews was extended during face-to-face interviews by a researcher (MH) working in the liaison service at the institution (this face-

to-face method has proven effective in terms of participation [22]). The interview guide is included in the appendix.

Data collection

Recruitment took place from February 2025 to May 2025. Data were intended to be collected from two sources: individual interviews and focus groups to enhance data completeness [23]. Triangulation of data collection methods is increasingly recommended as a strategy for achieving a more comprehensive understanding of phenomena.

I. Focus groups

For care teams: nursing assistants and nurses. Focus groups are a suitable option for research and evaluation in the field of health, especially for topics in which it is necessary to incorporate the perspective of patients, users, or the population at which HCPs' actions are aimed [22,24]. The aim of these focus groups was to give everyone the opportunity to speak and to examine non-verbal group behavioural dynamics (which may be representative of what occurs in CSMs) without the presence of hierarchy, as we hypothesised that speech might be less free or that discourse might be modified if nurse managers or physicians were present, due to the importance of social norms governing a group [25]. The focus groups were recorded in their entirety, always after obtaining each participant's permission to record it in the informed consent. In addition, observations and key data were collected in the researchers' field notebooks by means of notes. After transcribing the information obtained in the groups into Office documents, the recording was securely deleted. At the same time, a numerical code was assigned to name each participant so that any data that could identify the participant disappeared, thus ensuring anonymity. We estimated the interviews would take approximately 30 minutes.

II. Individual interviews

Individual interviews were conducted with physicians, residents, social workers, and nurse managers. We did not conduct focus groups within this population due to the multiplicity of professions and for feasibility reasons (schedule conflicts). Interviews were conducted face-to-face using a semi-structured schedule similar to the focus group guide (see online supplemental materials), were audio-recorded and transcribed verbatim. Field notes were used to explore researcher reflexivity and to further support the interpretation of data.

Data analysis

Data were analysed following the six steps of Braun and Clarke's thematic analysis [21]: familiarizing the researchers with the data, generating initial codes, identifying themes, reviewing these themes, defining them, and then writing up the analysis. A fully inductive analysis was performed, in which themes emerged after grouping meaning units and common meaning groups [21]. A theme is defined as a regular and meaningful pattern in participants' discourse capturing important elements of the data in relation to the research question and representing a structured level of response or meaning across the dataset [21]. In order to obtain validated and rigorous data, all stages of the analysis were discussed within the scientific team. After repeated and thorough reading of the transcripts of all interviews, two investigators (MH working within the institution and VB being which is external to the institute) built and tested a coding grid, which was discussed and validated by LF (providing methodological expertise endorsement).

Ethics

Our study received, on 24/02/25, a favourable opinion from the internal ethics committee of cancer centre (number 2025 499).

Results

Participants

Twenty participants took part in this study. When participants were approached individually, all participants agreed to participate (with the exception of one. The reason given was that the participant didn't have enough time to participate in the study). Overall, everyone was pleased with this experience. Two focus groups were cancelled due to busy schedules of the participants.

The characteristics of the participants are summarized in Table 1.

Sex /Ratio (m/f)	1/10	2/2	1/4
Departments	Service that participates in the CSM regularly	Service not participating or	Supportive Care

		participating only rarely in CSMs	
Roles and numbers of years of experience in oncology	1 Senior Manager (25 years) 5 Nurses (respectively 2, 4 ,4,2,2 years) 4 residents (respectively 4, 6, 4, 1 years) 1 nursing assistant (15 years)	1 Head nurse (15 years) 1 nurse (13years) 2 oncologists (respectively 7 and 6 years)	1 psychologist (14 years) 1 social worker (2 years) 3 Physicians (Psychiatrist Addiction Specialist, Palliative Care Physician) (respectively 5, 7 and 12 years)
Mean satisfaction rating regarding CSMs	6,4	1 refusal to grade (*) 8	7,2

Table 1: Demographic characteristics, professional information and average satisfaction rating of the study sample

(*)The reason given was that the participant hadn't attended enough CSMs meetings to be able to grade

The three major themes revealed by the analysis and their subthemes are presented in Table 2.

The three main themes revealed by the analysis and their sub-themes	
I. CSMs assessment: strengths, weaknesses and prospects	I.1 Strengths of CSMs *Multidisciplinarity* *A place for personal and practice enrichment*

	Emergence of a sense of belonging I.2 Weaknesses of CSMs and perspectives *Organisational difficulties* *Absence of the referring oncologist* *Challenges in group management*
II. A decision-making tool	II.1 Absence of a point of reference and inability to make decisions II.2 Purpose of this space: decision-making II. 3 Space generating negative emotions II. 4 Absence of the patient in this space II. 5 Power struggles surrounding decision-making
III. Place of institutional conflict	III.1 Conflicts between different professions III. 2 Meritocracy III. 3 The patient's voice as an issue III.4 Conflicts resolved in cases of urgent decision-making/if the situation deteriorates

Table 2: The 3 major themes revealed by the analysis with their subthemes

I. Assessment of CSMs: strengths, weaknesses, and perspectives

I.1 Strengths of CSMs

Multidisciplinarity

The analysis shows that one of the strengths highlighted by all participants is the multidisciplinary aspect of these meetings. This is deemed beneficial for the decision-making process, notably by improving and sharing the outcome of the meeting amongst the various HCPs. One physician emphasised: *"by definition, with several people, we are less bad than alone."*

This occurs through the induced plurality of perspectives and competences on the same situation, but also in order to have *"a global view"* (a notion raised by five participants), through the reminder of anamnesis and clinical information that are not often known by everyone, and through the intersection of temporalities between outpatient professionals who have a more longitudinal view (as they have followed the patient for a long time) and inpatient professionals who have a more transversal view of the situation. This also allows professionals *"to understand each other"* and *"to be on the same page"* according to the expression used by a nurse.

The multidisciplinary aspect also ensures shared responsibility: "it is a guarantee" for the decision-maker and for the patient. Indeed, the collegial nature gives weight to the decision taken. A nurse manager explained: *"telling the patient it was decided as a team is not the same…"* and *"it goes much better with families when you decide as a team."*

Finally, being several people, and particularly with professionals external to the inpatient unit where the CSM takes place, makes it possible to introduce a third party and therefore facilitate dialogue within a team. A head nurse stated: *"We can dialogue a bit more easily with an external professional."*

A place for personal and practice enrichment

Three participants pointed out that CSMs could constitute a meaningful setting for learning and professional development. This learning dimension extended beyond the acquisition of technical or organizational knowledge and was closely intertwined with a sense of active contribution to collective care. Participants described how being able to bring ideas, share expertise, and influence discussions reinforced their feeling of usefulness and professional

legitimacy. Such recognition appeared to support sustained engagement and motivation, as participants perceived CSMs as places where their cognitive and professional resources were acknowledged. One physician stated: *"when I bring something, I feel at my place and legitimate […] and I really feel useful."* Similarly, a nurse manager emphasized the importance of intellectual recognition in her professional trajectory, stating: *"I stayed at Gustave Roussy […] because I have the right to think and express myself."*

Emergence of a sense of belonging

Three participants reported that CSMs helped them feel supported and fostered a sense of belonging. This supportive dimension was closely linked to the collective dynamics of CSMs, where shared reflections and mutual exchanges allowed participants to try and cope with challenges collectively rather than individually. In line with the learning and empowerment processes previously described, participants emphasized also that a positive feeling of being supported emerged as well from such experience of being part of a coherent professional group in which roles, responsibilities, and difficulties can be acknowledged and shared. As one physician stated, *"participants may feel supported and strengthened,*" adding that "*we are not alone carrying this, we feel we are part of a whole.*"

I.2 Weaknesses of CSMs and perspectives

Organisational difficulties

Twelve participants highlighted organisational difficulties (differing across departments) as a limitation of CSMs and emphasised several areas for improvement: notifying participants in advance by email in order to maximise attendance (the referring physician's attendance, or that of the patient's nurse to anticipate staff rotations). Easier registration, for each professional group, of patients to be presented was also raised (nursing assistants, for instance, would tend not to be consulted according to one participant). Having a dedicated place was mentioned by four participants: a place where professionals would not be interrupted (most CSMs take place at nursing stations).

One participant said *"There are some rooms that are not suitable. It's unbearable to have computers in the middle [...], the telephone ringing, no, it's not possible, and the person answers[...] I think that for it to work well, we need to review the physical environment and the verbal environment."*

The possibility of systematically producing a meeting report was highlighted by three participants, so that different stakeholders can rely on it afterwards for the main lines of care

management or to support decisions vis-à-vis the patient or families. The importance of managerial involvement to address these organisational difficulties was emphasised.

One participant said *"Ideally, everything should be documented. I am a mediator, I follow up on complaints [...] It's true that when you have a report from the CSM ruling and families are complaining, it's much easier to rely on it."*

It should be noted that meeting frequency elicited contradictory statements: some participants would like to schedule a dedicated weekly time systematically, while others pointed out the time-consuming nature of this programme and would prefer CSMs to be requested only when needed.

Absence of the referring oncologist

The absence from CSMs of the patient referring oncologist within the hospital was raised by eight participants. Many participants suggested that the referring physician's presence should be systematic. One participant proposed that in case of the referring physician's absence, they should be replaced by a committee member (i.e., the multidisciplinary deliberation body that decides on care management).

One participant said: *"When discussing a patient, the referring physician is the key protagonist [...] but there are constraints and they cannot always be present. The idea, therefore, would be to have a specialist on the committee who could be available during the CSMs."*

Challenges in group management

Managing the group of participants was also identified as a difficulty. Indeed, allocated speaking time was perceived as too limited (regardless of profession), either because it was not distributed, or because there was an inhibition dimension: fear of being judged, reported by six participants across different roles.

One participant said: *"it is a bit of a witch-hunt […] the person targeted in an CSM will be targeted by everyone" […] "the physician is in the dock."*

It should be noted, as an illustration of this inhibition dimension, that all focus groups planned with care teams had to be cancelled (for organizational reasons: lack of participants called to other tasks, forgetfulness…).

There would also be a shifting of positions, highlighted by one psychologist: *"I could feel a dimension of struggle to take the floor […] and to assert it. […] There are statements that can overlap a little." "And roles get a bit mixed up."*

Several participants reported that it is very important to have, during these meetings, someone who can be the "*orchestra conductor,"* the "*time-keeper"* someone trained in group management. Three participants also reported the importance of reminding everyone about the rules at the start of the meeting: notably the importance of introducing oneself and one's role, that everyone's voice is welcome, as well as the importance of respecting the other's voice.

II. A decision-making tool

For ten participants, the objective of CSMs is to decide on one aspect of care management. The lexical field used around decision-making is highly positive "*the real one*," "*the good one*," "*the only one*" paradoxically given the complexity that many highlight in clinical situations. For six participants, the decision-making issue concerns the transition from curative to palliative care.

However, this tool represented by CSMs is made void by the absence of the decision-making authority, embodied by the referring physician. A supportive care team member said: "*when attending the CSM, the medical decisions have already been made. We feel it. And colleagues know about it. They can feel it. […] There is a subsequent feeling of uselessness."*

This impossibility generates feelings of anger, uselessness, or discouragement, expressed in four times. Conversely, when the exchange provides clarification and decision support, participants' feedbacks are more positive and described as "*satisfaction*" by three participants: *"In situations where I can offer my insight, my expertise is taken into account, which is very satisfying."*

Another difficulty for decision-making would be a temporality issue described by three participants: due to the time needed to set up a CSM, some decision-making processes might be delayed or already taken elsewhere.

One participant said: *It feels like we wait a very long time when we have a problem in a complicated situation, and it's only after a while that we decide to present the situation to the CSM […] which delays things, which aren't necessarily done because we're waiting for the*

CSM. […] and what's more, we (the paramedic teams) work on a rotation system, so we're not there all the time, so we might not have been there for the CSM.

The main difference in the discourse between departments that carry out CSMs and those that do so only rarely, centres on this decision-making issues. Indeed, for departments that rarely carry out CSMs, there appears to be an overlap between different programmes (CSMs, MDMs…) with common objectives. For example, decisions would be made, according to three physicians, in other strictly medical spaces such as MDMs. The objective of CSMs, according to one of them, would be educational, providing understanding keys for paramedical staff.

One participant said: *"I think that CSMs should be something that does not duplicate MDMs [...] it's a space for discussion [...] it is not a space for medical decision-making."*

A nurse from a department that rarely uses CSMs reports that these spaces could help to better understand the decisions made or serve as a useful tool for emotional support: *"We would have a better understanding of the decisions made […] and it would be easier to convey the distress experienced by staff in end-of-life situations to an external professional."* These points are not raised by participants from the departments where CSMs are held on a regular basis.

It is important to emphasise that no participant mentioned patient involvement in this decision-making process with the exception of one nurse who suggests that patients are not included in the CSMs because "*it is complicated, patients, as soon as you give them a curative solution, they always take it*".

III. A space of institutional power stakes

These meetings can highlight or reveal institutional stakes. Indeed, participants may feel in opposition to other professional groups, and find it difficult to work together. One physician stated: "*CSMs work if people are willing to participate.*"

These tensions could be highlighted during CSMs via the decision-making process, as written above, but also in each professional group's relationship to the patient. Indeed, each professional group would claim to have the "*true*" version of what the patient wants. One resident said: "*the referents are the physicians who know the patient the best, who he is.*" Conversely, one nurse said: "*actually, we are the patient's voice.*"

Tensions are visible in participants' discourse about their place in CSMs, with the impression that they are often useful for other professional groups but not for their own. One nurse said

about physicians: "*CSMs allow them to cover their backs*". One physician says: *"CSMs provide a forum for nurses to speak out*".

It should be noted that participants nuanced their statements: these tensions seem to stop as soon as CSMs are "*really wanted*", as one participant put it, often in situations described as very acute, with an urgent need for a decision. One physician said: "*in emergency situations, there are no score-settling […] we do not abandon our friends.*"

Discussion

1. Highlights

This study explores HCPs' feedback regarding CSMs after 10 years of implementation in a large cancer centre.

Our results highlight that the contribution of multidisciplinarity and being together operates at different levels for HCPs: for the decision-making process, but also from a learning and sense of belonging perspective. This was unanimously highlighted by participants.
Nevertheless, this multidisciplinarity is also a source of challenges, particularly at the decision-making level. The frequent absence of the referring physician, (who is the decision-maker) could reinforce the impression described by some participants that decisions are made outside of the CSMs [26]. This point has already been reported in another study across 39 countries [7]. According to our study results, this absence could be caused by the referring physicians' lack of time, overlap between different programmes with common objectives and by an avoidance some institutional tensions, which is also described in other studies [27,28]. In addition, participants emphasised other group functioning issues, such as speaking rules during meetings and notably how communication takes place and is shared. These dynamics and issues around communication may reflect implicit power relations and underline that CSMs are not only a clinical discussion but represent also a space to show knowledge and power beyond decisions about patient trajectories. These two points (absence of the referring physician and difficulties in group management) could therefore weaken the contribution of multidisciplinarity and contribute to lower participant satisfaction with CSMs when they are repeated, as evidenced by lower ratings in departments where they are conducted frequently compared to others.

It should be noted that these institutional tensions tended to dissipate in emergency situations and show that a shared objective reduces the sense of hierarchical weight. Similarly, studies

described that emergency situations act as a catalyst for interprofessional cooperation in hospitals: HCPs refocusing on a common goal [29,30].

2. Patient involvement in the SDM process:

If practices of decisional ethics are in place with the aim of SDM, it can be questioned that, in the most complex cases addressed in CSMs, decisions are made without active patient participation, even though the question of the patient's preferences is systematically raised during the CSMs. In our results, the fact that patients and their families do not participate in CSMs was raised only once during the interviews.

Several hypotheses can be proposed: first, CSMs have historically been conceived as a space that follows in the tradition of MDMs, focusing on biomedical expertise rather than shared decision-making [28].

Second, HCPs' perceptions of this involvement appear to be largely unfavourable. Our participant stated that, in her view, patients always chose the curative care option. Studies on MDMs in cancer care report that professionals tend to involve the patient more after discussing the various options that are reasonable in principle [14,31] and to avoid disagreements or hesitations in the patient's presence [32]. According to HCP, this could increase patient anxiety [32,33].

Finally, it is possible that oncologists feel a very high level of personal responsibility regarding the complex clinical situations discussed in the CSMs, which limits shared decision-making. Thus, certain studies in neonatology show that, from a medical standpoint, in more complex situations with a high probability of death, neonatologists feel a stronger sense of decision-making responsibility and involve parents less in decision-making processes [34–36].

CSMs could be the right place for patient involvement in SDM the process. They are less constrained by time than MDMs, as often only a single case is discussed (time constraints are one of the main barriers cited to patient involvement in MDMs) [37]. Furthermore, it has been shown that the treatment priorities of patients and physicians are not necessarily the same in cancer [38,39]. These results could be further accentuated in complex situations. It in life-threatening situations patient preferences are described as unlikely pre-existing, dynamic, and reversible outcome of an interaction [40]. The fact that this interaction can be reflective, multi-professional, and take place within a setting such as the CSMs could be an interesting option.

3. Organisational and temporal perspectives for improvements

As highlighted by Keating et al. and Lamb, the functioning of multidisciplinary oncology meetings and of CSMs depends on various factors, such as organisational and temporal components [29,41].

CSMs could benefit from the following measures:

- Structural reinforcement with the systematic implementation of a trained moderator, as well as the patient's referent or a medical committee member (i.e., a physician responsible for assessing a situation and issuing recommendations on care management), in order to guarantee an optimal group dynamic and to ensure decision enforcement.
- The definition of clear objectives for participants at the beginning of each meeting and the implementation of a more ordered and systematic framework for selecting patients to be presented, inviting participants, dedicated locations, meeting reports, etc. For example, Colombat et al suggest giving the discussion a clearer structure and recommend that care assistants and nurses speak first, with doctors speaking last. They also advocate the 'three rounds of discussion' technique: The first to assess the clinical situation, the second to propose treatment plans, and the last to validate the proposal that has gained consensus [42].
- The importance of a proactive temporality, with triggering CSMs based on anticipated clinical criteria (complex decisions, key turning points).
- The opportunity to involve patients more directly with a view to improving the shared decision making process.

4. Strengths and limitations of the study

A notable strength of this research is the focus on the perspectives from various HCPs, allowing for diverse, comparative insights into how each group experiences CSMs. The study thoroughly captures and contrasts the viewpoints of all parties involved.

However, this study faced several limitations. The first relates to sample representativeness. It consisted of volunteers recruited through a face-to-face approach by an evaluator. The avoidance and "self-inhibition" dimension identified by one participant during CSMs may

therefore have been underestimated. The second limitation was the impossibility of conducting focus groups among paramedical staff. This may illustrate organisational difficulties inherent to the workload pressure due to high intensity care in oncology as well as possible avoidance behaviours.

Conclusion

Despite these limitations, this study, 10 years after the implementation of CSMs in an oncology institution, investigates HCP' feedback regarding these meetings. They constitute a promising initiative to advance collective reflection and improve care. Moreover CSMs could provide an interesting forum for patient involvement in the SDM process. Given the innovative nature of this programme, it may be of interest in the future to evaluate the relevance of CSMs through patient satisfaction and HCP' well-being.

Declarations

Ethics approval and consent to participate

Our study received, on 24/02/25, a favourable opinion from the internal ethics committee of cancer centre (number 2025 499). All participants gave their informed consent to take part.

Consent for publication

Not applicable

Availability of data and material

All data used in this article are derived from qualitative interviews that have been transcribed and are available upon request from the corresponding authors.

Competing interests

The authors have not competing interests

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Authors' contributions

M. Hermand conceived the study, conducted and analysed the qualitative interviews, and drafted the manuscript with the assistance of V. Bernard (student). L. Fasse supervised the study,

provided methodological and scientific guidance throughout the research process, and critically reviewed the manuscript. F. Blot and F. Butlen critically revised the manuscript and contributed to improving its intellectual content. J.B. Le Provost and F. Scotte facilitated the implementation of the study by providing institutional support and overseeing the ethical aspects of the project. All authors read and approved the final manuscript.

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Annexe :

The Coreq check list

Domain 1: Research team and reflexivity	

Personal Characteristics	
1. Interviewer/facilitator Which author/s conducted the interview or focus group?	The interviews were conducted by Dr. Marianne Hermand, and the focus groups by Dr. Marianne Hermand and Vanessa Bernard.
2 . Credentials What were the researcher's credentials? E.g. PhD, MD	Investigateur principal : Dr Marianne Hermand (MH) is a psychiatrist MD Dr Vanessa Bernard (VB) is a psychiatrist MD Pr Leonor Fasse (LF) is a female associate professor in psychology and an expert in qualitative methodology.
3. Occupation What was their occupation at the time of the study?	MH is a liaison psychiatrist at the large cancer centre in Paris and a member of the ethics committee. VB is a resident and not doing a rotation at this hospital. LF is a senior lecturer and liaison psychologist at the same cancer centre.
4. Gender Was the researcher male or female?	Researcher are female
5. Experience and training What experience or training did the researcher have?	MH is new to qualitative research but has published articles using a quantitative methodology. LF has already published numerous articles using a qualitative methodology. This work is part of VB's doctoral thesis.
Relationship with participants	
6. Relationship established Was a relationship established prior to study commencement?	The participants work in the same facility as MH and LF and may have direct contact depending on the

	care of certain patients. No relationship existed between VB and the participants
7. Participant knowledge of the interviewer What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	MH who conducted the interviews, is known to work at the cancer centre, participates in the CSMs and is a member of the ethics committee. She is a psychiatrist and has already published articles on the topic of workplace suffering among healthcare professionals. It is known that LF is a psychologist, belongs to the cancer centre, participates in the CSMs and is a member of the ethics committee. It is known that VB is a resident and that this topic relates to his doctoral thesis.
8. Interviewer characteristics What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	MH belongs to the cancer centre, and institutional biases may therefore exist, but not for VB.
Domain 2: study design	
Theoretical framework	
9. Methodological orientation and Theory What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Thematic analysis was used due to the novice status of MH and VB in qualitative research. Furthermore, this methodology is suitable for research concerning healthcare professionals (Kivits J 2016 : les recherches qualitatives en santé Armand colin (Cairn)
Participant selection	

10. Sampling How were participants selected? e.g. purposive, convenience, consecutive, snowball	The services to which participants depended (excluding supportive care) were randomly selected. Participation was then based on voluntary participation. Regarding supportive care, participants were selected on a voluntary basis.
11. Method of approach How were participants approached? e.g. face-to-face, telephone, mail, email	Face to face to encourage participation) and email were used.
12. Sample size How many participants were in the study?	The concepts of data saturation and the power of information will be used. Therefore, it is not possible to predict the number of participants. However, for the focus groups, it is planned to include between 4 and 10 people according to the rules of good conduct (Carlsen).
13. Non-participation How many people refused to participate or dropped out? Reasons? Setting	A flowchart with the number and reasons for non-participation will be provided.
14. Setting of data collection Where was the data collected? e.g. home, clinic, workplace	The data will be collected and processed at the cancer centre
15. Presence of non-participants Was anyone else present besides the participants and researchers?	No
16. Description of sample What are the important characteristics of the sample? e.g. demographic data, date	-Sex -Profession -Number of years worked in oncology -Number of years worked at cancer centre
Data collection	

17. Interview guide Were questions, prompts, guides provided by the authors? Was it pilot tested?	The semi-structured interview was developed by VB and MH and submitted to LF. The questionnaire was developed following a literature review conducted by VB. The pilot program was tested.
18. Repeat interviews Were repeat interviews carried out? If yes, how many?	The interviews were repeated twice.
19. Audio/visual recording Did the research use audio or visual recording to collect the data?	The interviews were recorded using audio equipment.
20. Field notes Were field notes made during and/or after the interview or focus group?	Field notes were taken in the field by VB during the focus groups (which were primarily facilitated by MH.
21. Duration What was the duration of the interviews or focus group?	Between 15 and 30 minutes (no longer due to feasibility reasons, as the healthcare professionals were interviewed during their working hours).
22. Data saturation Was data saturation discussed?	Data saturation was discussed (according to the article by Braun and Clarke), and the principle of information power was chosen (ref. 23).
23. Transcripts returned Were transcripts returned to participants for comment and/or correction?	No
Domain 3: analysis and findings	
Data analysis	
24. Number of data coders How many data coders coded the data?	Two data coders coded separately: MH and VB
25. Description of the coding tree Did authors provide a description of the coding tree?	We will provide a detailed description of the coding tree.
26. Derivation of themes Were themes identified in advance or derived from the data?	Themes are derived from data

27. Software What software, if applicable, was used to manage the data?	No
28. Participant checking Did participants provide feedback on the findings?	Yes, the article will be sent by e mail
Reporting	
29. Quotations presented Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number	Yes, the data will be illustrated with verbatim examples and anonymized.
30. Data and findings consistent Was there consistency between the data presented and the findings?	We will strive for consistency.
31. Clarity of major themes Were major themes clearly presented in the findings?	We will clearly present the major themes.
32. Clarity of minor themes Is there a description of diverse cases or discussion of minor themes?	We will clearly present the minors themes.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Table.docx
- Thesemidirectedinterview.docx