Comparative Assessment of Multidisciplinary Team (MDT) Approaches in Geriatric Palliative Care (GPC) In Selected Federal University Teaching Hospitals in Nigeria

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ABSTRACT

Geriatric palliative care requires coordinated responses to the complex physical, psychosocial, social and spiritual needs of older adults with life-limiting illnesses. Although multidisciplinary teamwork is widely regarded as fundamental to quality palliative care, empirical evidence concerning how such teams are actually structured and function within Nigerian tertiary hospitals remains limited. This study comparatively assessed multidisciplinary team approaches to GPC in ABUTH, Zaria; UCH, Ibadan; and UNTH, Enugu. The objectives investigated structure, teamwork models, decision-making, outcomes and operational challenges of MDTs involved in GPC. A mixed-methods survey design was employed. Quantitative evidence comprised 208 analysed questionnaires, while qualitative evidence comprised 20 IDIs and 6 KIIs, supplemented by observation and organisational ethnography. Quantitative data were analysed using frequencies, percentages, and regression models; qualitative data were analysed thematically and integrated comparatively with the quantitative findings. All three institutions demonstrated multidisciplinary configurations involving physicians, nurses, pharmacists, social workers and allied professionals. However, dedicated GPC subunits remained weakly institutionalised: 39.4% of ABUTH, 41.0% of UCH and 39.0% of UNTH respondents reported that no specialised GPC subunit existed. Shared decision-making was the dominant reported model at ABUTH (57.6%), UCH (59.0%) and UNTH (66.1%), although qualitative evidence revealed persistent physician authority, particularly at ABUTH and UNTH. UCH demonstrated comparatively stronger institutional coordination, reflection and holistic integration; ABUTH combined clinical competence with more pronounced hierarchy; and UNTH displayed adaptive teamwork alongside greater infrastructural restraints. Resource limitations were the leading challenge, reported by 45.5%, 47.0% and 50.9% respectively. MDT presence alone is insufficient to produce integrated GPC. Effective practice requires institutionalised coordination, multidisciplinary participation, and workforce development, culturally responsive decision-making and sustained organisational support. The study provides a comparative Nigerian evidence base demonstrating how the same broad MDT model can produce different functional outcomes according to institutional structure, integration, resource capacity and professional relationships.

KEYWORDS

Geriatric palliative care, multidisciplinary teams, teamwork, decision-making, Nigeria health systems

I. INTRODUCTION

A. Background

Geriatric palliative care occupies an increasingly important position within health systems because older adults with life-limiting illnesses frequently experience multimorbidity, frailty, functional decline, psychosocial vulnerability and complex family-care demands. Palliative care is concerned not only with disease management but with relieving suffering and improving the quality of life of patients and their families. Its holistic orientation therefore requires the integration of clinical, psychosocial, social and spiritual expertise rather than reliance on a single professional perspective.

The complexity of GPC makes multidisciplinary teamwork particularly important. Physicians, nurses, pharmacists, social workers, rehabilitation professionals, psychologists and spiritual-care providers may each encounter different dimensions of the same patient's needs (Clark, 1999). The value of MDT practice consequently depends not simply on assembling professionals but on their capacity to communicate, coordinate, deliberate and act around shared goals. Inter professional collaboration has been associated with improvements in professional practice and healthcare outcomes, although the benefits depend substantially on how collaboration is organised and implemented.

The challenge is especially significant in low- and middle-income settings where specialist workforce capacity, infrastructure, financing and palliative-care policy may be limited. In Nigeria, palliative care has developed through important institutional and professional initiatives, but its distribution and integration remain uneven.

B. Problem Statement

Nigerian scholarship has documented important clinical, educational and policy developments, yet comparatively little empirical attention has been directed towards the organisational dynamics of MDTs delivering GPC. Existing evidence also tends to describe professional composition without sufficiently explaining how hierarchy, communication, institutional support and contextual constraints shape the actual functioning of teams. This gap is consequential.

A team can be formally multidisciplinary while remaining operationally hierarchical; professionals can be present without participating meaningfully in decision-making; and palliative-care services can exist without a clearly defined GPC structure. The Nigerian context therefore requires analysis that moves beyond the question of whether MDTs exist to examine how they function.

ABUTH, UCH and UNTH provide an analytically useful comparison because they represent major tertiary institutions operating in different geographical and institutional environments. The present study therefore examines the structure, teamwork models, decision-making processes, outcomes and challenges of MDT approaches to GPC across the three institutions. Its central argument is that MDT effectiveness is produced through the interaction between

organisational structure and everyday professional practice rather than through team composition alone.

II. LITERATURE REVIEW AND THEORETICAL FOUNDATION

A. Conceptual framework

GPC combines the holistic philosophy of palliative care with the distinctive needs of older adults. The study conceptualises MDTs as groups of health and allied professionals who contribute specialised expertise towards coordinated patient care. Three broad teamwork orientations are relevant. In a multidisciplinary model, professionals largely retain discipline-specific roles and contribute to a common care process. Interdisciplinary practice involves greater integration, joint planning and shared decision-making, while Tran's disciplinary practice involves greater flexibility and role-sharing across professional boundaries.

The distinction is important because the presence of multiple professions does not automatically establish inter professional integration. Communication, role clarity, leadership, shared goals and institutional support determine whether professional diversity becomes genuine collaborative practice. The study therefore considers MDT structure, teamwork model, decision-making, cultural and religious sensitivity, institutional support and resource availability as interconnected dimensions of GPC functioning.

B. Theoretical Framework: Parsons' Structural Functionalism and the AGIL Framework

The study is theoretically anchored in Talcott Parsons' structural functionalism, particularly the AGIL framework. Parsons (1951) conceptualized social systems as interconnected structures whose continued functioning depends on fulfilment of four functional imperatives: Adaptation, Goal Attainment, Integration and Latency.

Applied to GPC, Adaptation concerns the capacity of hospitals and MDTs to mobilise resources, personnel, infrastructure and technology necessary for care. Goal Attainment concerns the capacity of teams to align professional activities around the goal of improving quality of life and relieving suffering. Integration concerns communication, coordination, shared decision-making and management of relationships between professional groups. Latency concerns the maintenance of values, norms, professional commitment and organisational practices that sustain teamwork over time. The framework helps explain why apparently similar MDT structures operate differently. A hospital may possess professional diversity but experience weak Integration because information sharing is delayed or decision-making remains physician-dominated. Similarly, inadequate resources represent an Adaptation problem that can subsequently undermine Integration, workforce morale and Goal Attainment.

Structural functionalism nevertheless has limitations. Its emphasis on equilibrium can obscure professional power, conflict, inequality and competing interests. The empirical findings demonstrate precisely why this qualification is necessary: physicians may formally lead teams while allied professionals possess relevant expertise but limited decision-making authority. The AGIL framework is therefore used here as an organising analytical lens rather than as an assumption that healthcare systems naturally operate harmoniously.

III. METHODOLOGY

A. Research Design

The study employed a survey-oriented mixed-methods design combining quantitative and qualitative approaches. Questionnaire data provided a comparative institutional profile, while interviews, observation and organisational ethnography provided contextual explanations of team behaviour, hierarchy, communication and decision-making. The use of multiple sources enabled the study to examine both the reported structure of MDTs and their observed and experienced functioning.

B. Study Settings

The study was conducted in three Nigerian tertiary teaching hospitals: ABUTH, Zaria; UCH, Ibadan; and UNTH, Enugu. The institutions were selected because of their involvement in tertiary healthcare and palliative-care services and their relevance to comparative examination of MDT practice. The study's institutional comparison focused on how palliative and geriatric care were organised within these settings rather than assuming that the three hospitals possessed identical organisational structures.

C. Population and Participants

The documented population frame comprised 11,144 personnel: ABUTH 3,358, UCH 6,563 and UNTH 1,223. The analysed questionnaire dataset contained 208 responses: 66 from ABUTH, 83 from UCH and 59 from UNTH. The qualitative component comprised 20 IDIs and six KIIs, supplemented by observation and organisational ethnography. The research record also contains a planned questionnaire allocation of 94 for ABUTH, 67 for UCH and 59 for UNTH (220 in total). Because the reported 83 UCH returns exceed the stated planned UCH sample of 67, the sampling figures require reconciliation with the original fieldwork records before publication. This paper does not manufacture a correction.

D. Sampling and Data Collection

The study combined proportional sampling with purposive selection of relevant professionals and institutional informants. Questionnaire data were collected from MDT-related personnel, while IDIs and KIIs elicited accounts of team organisation, communication, decision-making and institutional constraints. Organisational ethnography supplemented these accounts by examining MDT practice in its institutional setting. At UCH, for example, the researcher participated in case presentations and patient reviews; at UNTH, participation included activities within the oncology/navigation setting; and the researcher's professional involvement at ABUTH provided additional observational access.

E. Data Analysis and Integration

Quantitative data were coded and analysed using SPSS Version 31. Descriptive statistics included frequencies and percentages. Chi-square tests examined institutional differences, while multiple linear, binary logistic and multinomial logistic regression models were used to examine predictors and institutional differentiation. The qualitative material was organised thematically around the study objectives. Integration occurred through comparative triangulation. Quantitative patterns were first identified and then examined

against interview, observational and organisational evidence. Convergence was interpreted where the sources supported the same conclusion; complementarity where qualitative evidence explained a quantitative pattern; divergence where the sources pointed in different directions; and expansion where qualitative evidence revealed dimensions not adequately captured by the survey.

IV. RESULTS

A. MDT Structure

All three institutions demonstrated multidisciplinary configurations involving physicians, nurses, pharmacists, social workers and allied professionals. However, the organisational visibility of GPC remained limited. The general ward was the principal reported location of GPC: 54.5% at ABUTH, 56.6% at UCH and 45.8% at UNTH. Dedicated palliative-care locations were reported by 27.3%, 26.5% and 25.4%, respectively.

Physicians predominantly occupied formal leadership positions: 60.6% at ABUTH, 63.9% at UCH and 69.5% at UNTH. Nurse-only leadership was more common at ABUTH (33.3%) and UCH (27.7%) than UNTH (20.3%). Shared doctor-nurse leadership was uncommon.

Most importantly, only 22.7% of ABUTH respondents, 14.5% of UCH respondents and 30.5% of UNTH respondents reported the presence of a specialised GPC subunit. Conversely, 39.4% at ABUTH, 41.0% at UCH and 39.0% at UNTH reported that no such subunit existed, while substantial proportions were unsure. This suggests weak institutional visibility and formalisation of GPC.

The qualitative evidence added an important organisational dimension. UCH was characterised by more structured and documented coordination, whereas ABUTH demonstrated a consultant-led structure with relatively balanced professional representation. UNTH displayed greater fluidity and role adaptation but also greater infrastructural constraints. Thus, professional headcounts alone understated meaningful differences in team functioning.

B. Teamwork Models

The questionnaire data showed that multidisciplinary practice remained dominant. The study's chi-square analysis found no statistically significant institutional difference in the distribution of the examined service/teamwork categories: $\chi^2 = 3.328$, $df = 4$, $p = .5045$. However, qualitative evidence complicated this apparent uniformity. UCH demonstrated more multidirectional interaction and greater integration of professional voices. ABUTH was more consultant-led and relatively unidirectional, while UNTH relied more heavily on pragmatic and event-driven collaboration. This distinction is important: statistical similarity in the nominal distribution of teamwork categories did not imply functional similarity in practice.

C. Decision-Making

Shared decision-making was the most frequently reported model: 57.6% at ABUTH, 59.0% at UCH and 66.1% at UNTH. Patient and family inclusion was also widely reported. Nevertheless, qualitative findings revealed persistent professional hierarchy. At ABUTH, participants described the consultant as the final authority. At UCH, participants described more genuine debate and negotiation between professional groups. At UNTH, senior medical authority remained influential despite the high survey reporting of shared decision-making. This is a central mixed-method finding: reported shared decision-making coexisted with experienced hierarchical decision-making. The divergence suggests that respondents may understand "shared decision-making" as consultation or contribution rather than equal distribution of decision authority. Ethical frameworks were reported as frequently considered across all three institutions. Family dynamics and cultural and religious considerations were also incorporated into decision-making, demonstrating the importance of sociocultural context in GPC.

D. MDT Treatment Outcomes

More than 80% of respondents across each institution indicated that MDT collaboration moderately or significantly improved patient-care outcomes. "Significant improvement" was reported by 47.0% at ABUTH, 47.0% at UCH and 40.7% at UNTH.

The qualitative evidence indicated that these benefits were unevenly distributed across outcome dimensions. ABUTH demonstrated clinically oriented benefits, including reported reductions in readmissions, but psychosocial and family needs were not always consistently integrated. UCH demonstrated stronger integration of clinical and psychosocial care, family engagement and structured reflection. UNTH demonstrated clinical gains but greater difficulties with continuity and follow-up.

Patient and caregiver accounts broadly converged on the value of professional coordination while identifying persistent financial, logistical and symptom-management burdens. Thus, MDTs appeared to improve care without eliminating the structural conditions that generate suffering.

E. Challenges

Resource constraints were the leading challenge to MDT decision-making at all three sites: 45.5% at ABUTH, 47.0% at UCH and 50.9% at UNTH. Differing professional opinions were the second most frequently identified challenge: 30.3%, 28.9% and 25.4%, respectively. Communication problems accounted for 15.2%, 14.5% and 17.0%.

- Similarly, 62.1% of ABUTH respondents, 59.0% of UCH respondents and 64.4% of UNTH respondents reported significant challenges associated specifically with working in GPC.
- Information-sharing delays were the most prominent communication barrier: 57.6% at ABUTH, 56.6% at UCH and 61.0% at UNTH.

- Burnout was noticeable across all three institutions. "Prevalent" or "very prevalent" responses together accounted for 40.9% at ABUTH, 39.7% at UCH and 47.5% at UNTH.
- Resource gaps were similarly widespread, with "some gaps and challenges" reported by 71.2% at ABUTH, 65.1% at UCH and 78.0% at UNTH.

Table 4.1: Mixed-Methods Triangulation

Major finding	Quantitative evidence	Qualitative evidence	Integrated interpretation
MDT structure	General wards were the main GPC location; specialised GPC subunits were reported by only 22.7% ABUTH, 14.5% UCH and 30.5% UNTH	UCH showed stronger formal coordination; ABUTH was consultant-led; UNTH was more fluid and resource-adaptive	The three institutions share multidisciplinary composition but differ substantially in organisational maturity and functional integration.
Teamwork	No significant statistical difference in teamwork/service-category distribution, p = .5045	UCH was more multidirectional; ABUTH more hierarchical; UNTH more pragmatic/adaptive	Convergence exists at the nominal model level, but expansion occurs through qualitative evidence showing functional differences.
Decision-making	Shared decision-making reported by 57.6%, 59.0% and 66.1%	Consultant authority remained prominent at ABUTH and UNTH; UCH showed greater debate and negotiation	Divergence between reported model and lived decision authority reveals the difference between consultation and genuinely shared power.
Outcomes	>80% in each institution reported moderate/significant improvement	UCH showed stronger psychosocial integration; ABUTH stronger clinical orientation; UNTH weaker continuity	Quantitative findings demonstrate perceived benefit, while qualitative evidence explains why benefits differ by outcome domain.
Resources	Resource limitations were the leading decision-making challenge at all sites	Participants described staffing, infrastructure, medication and funding constraints	Strong convergence establishes resource scarcity as a system-wide constraint rather than an institution-specific anomaly.

Communication	Information-sharing delays affected 57.6%, 56.6% and 61.0%	Participants described informal communication, delayed information and difficulty assembling teams	Quantitative prevalence is explained by qualitative accounts of weak communication infrastructure.
Workforce wellbeing	Burnout prevalence/very high prevalence was substantial, particularly at UNTH	Participants called for counselling, debriefing, retreats and institutional support	Staff wellbeing represents an important condition for sustainable MDT functioning.

The triangulation demonstrates why the study's contribution cannot be reduced to a comparison of percentages. Quantitative findings establish the distribution of perceptions; qualitative findings explain how apparently similar structures produce different experiences. In particular, the contrast between the high reported prevalence of shared decision-making and continuing accounts of physician dominance demonstrates the value of integrating methods rather than treating them as independent evidence streams.

F. Comparative Analysis: ABUTH, UCH and UNTH

The comparative evidence supports three distinct institutional profiles. ABUTH demonstrates a clinically competent but comparatively hierarchical model. Its MDT contains diverse professional groups and achieves positive perceived outcomes, but decision-making remains strongly consultant-oriented. Communication is less multidirectional, and resource adequacy remains a significant concern. Its principal opportunity is therefore to convert professional diversity into stronger participatory integration.

UCH demonstrates the strongest institutional maturity within the comparative evidence. Its structure is more formally coordinated, professional participation is more visible, team reflection is more established and psychosocial/family dimensions are more consistently incorporated. Nevertheless, UCH is not without limitations: resource constraints remain, and the existence of a specialised GPC subunit was not universally recognised by respondents.

UNTH demonstrates substantial adaptive capacity. It records the highest reported shared decision-making and strong cultural adaptation, but this is accompanied by infrastructural strain, uneven continuity and comparatively high staff burnout. Its flexibility appears to function partly as a response to resource constraints rather than simply as an organisational choice.

The study's statistical analysis reinforces the distinction between structural similarity and functional differentiation. MDT professional distributions did not differ significantly across institutions ($\chi^2 = 2.649$, DF = 14, $p = .9995$), while qualitative evidence demonstrated differences in leadership, role clarity, participation and integration.

V. DISCUSSION

The principal finding is that MDT effectiveness depends less on the mere presence of multiple professional categories than on the institutional conditions under which those professionals collaborate. This finding extends the conceptual distinction between multidisciplinary composition and interdisciplinary functioning. It also explains why the three institutions could display statistically similar teamwork categories while demonstrating substantially different organisational experiences. The limited institutionalisation of GPC is particularly important. Most GPC care occurred in general wards, and respondents demonstrated considerable uncertainty about specialised GPC structures. This suggests that geriatric palliative care remains organisationally embedded within broader clinical systems rather than consistently established as a distinct service pathway. Such embedding can preserve access to specialist clinical resources but may weaken continuity, visibility and ownership of GPC.

The findings also illuminate professional hierarchy. Survey respondents predominantly identified shared decision-making, yet interviews at ABUTH and UNTH repeatedly described final authority resting with senior physicians. The issue is therefore not whether other professionals are consulted but whether consultation produces meaningful influence. This distinction is consistent with literature showing that formal MDT structures do not necessarily eliminate professional dominance (Reeves et al., 2017). UCH provides the strongest evidence that institutional routines can modify these dynamics. Regular discussion, professional debate, reflection and broader participation create mechanisms through which integration becomes an organisational practice rather than an aspirational principle. The finding accords with evidence supporting structured inter professional collaboration and team-based practice.

From the AGIL perspective, the three institutions demonstrate different functional equilibria. Resource scarcity represents an Adaptation problem. Delayed information sharing and uneven participation represent Integration problems. Weak continuity or incomplete holistic care compromises Goal Attainment, while burnout threatens Latency, because exhausted professionals may find it increasingly difficult to sustain the norms and commitment required for collaborative practice. The AGIL interpretation is therefore useful precisely because the four functions are interconnected rather than independent.

At the same time, a purely functionalist interpretation would be incomplete. The persistence of physician authority despite nominally shared decision-making reveals professional power relations that cannot be explained solely through system equilibrium. The findings therefore support a critical use of structural functionalism: organisational structures matter, but so do power, hierarchy and unequal professional influence. The regression findings reinforce the organisational argument. Institutional support was a strong predictor of perceived GPC effectiveness ($\beta = .35$, $p < .001$), alongside technological MDT training ($\beta = .31$, $p = .001$), cultural sensitivity training ($\beta = .28$, $p = .012$), religious sensitivity training ($\beta = .22$, $p = .031$) and ethical dilemma discussions ($\beta = .19$, $p = .021$). The model explained 62% of the variance in perceived effectiveness ($R^2 = .62$; $F = 18.4$, $p < .001$).

These findings have an important Nigerian implication. The challenge is not simply to import a sophisticated international MDT model. Resource limitations, cultural expectations,

professional hierarchies and institutional arrangements mean that effective Nigerian models must be context-sensitive without becoming structurally informal. UCH illustrates the potential benefits of stronger institutionalisation, whereas ABUTH and UNTH demonstrate the importance of adaptive capacity under constraint. The findings also have international relevance. They demonstrate that MDT development in resource-constrained settings should not be evaluated solely through the presence of professional categories or formal service labels. Functional indicators participation, communication, shared authority, continuity, reflection and staff wellbeing may provide a more meaningful assessment of whether a team is genuinely interdisciplinary.

A. Limitations

The study has several limitations. First, its quantitative component is cross-sectional and therefore primarily captures perceptions and organisational conditions at the time of data collection rather than longitudinal change. Second, several outcome measures are perception-based rather than derived exclusively from validated patient-level clinical measures. Third, institutional differences in organisation, workforce and service configuration may influence comparability.

VI. CONCLUSION

This study demonstrates that multidisciplinary geriatric palliative care is present across ABUTH, UCH and UNTH, but that multidisciplinary presence and multidisciplinary functioning are not synonymous. All three institutions contain diverse professional groups and report positive effects of collaboration, yet the depth of integration differs. UCH demonstrates the strongest institutionalisation of collaborative practice; ABUTH combines clinical competence with stronger hierarchical tendencies; and UNTH demonstrates adaptive teamwork under greater infrastructural pressure. Across all three institutions, limited resources, information-sharing delays and staff burnout constrain the full realisation of holistic GPC. The evidence therefore indicates that strengthening GPC in Nigeria requires more than creating MDTs. It requires organisational structures that make collaboration routine, decision-making that gives meaningful voice to relevant professionals and families, adequate workforce preparation, culturally responsive practice and institutional systems capable of sustaining team performance.

RECOMMENDATIONS

- Healthcare institutions should establish clearly defined GPC service pathways and, where feasible, dedicated GPC subunits or clearly designated multidisciplinary service structures. Each institution should specify MDT membership, leadership responsibilities, referral pathways, documentation requirements and mechanisms for follow-up.
- MDT leadership should institute scheduled multidisciplinary case-review meetings with documented decisions, assigned responsibilities and follow-up actions. Meeting participation should extend beyond physicians to nurses, pharmacists, social workers and other relevant professionals.

- Medical and social-care professionals should receive continuing inter professional education covering palliative-care principles, communication, cultural and religious sensitivity, ethical deliberation and collaborative decision-making. The existing Nigerian interdisciplinary training experience provides a basis for further workforce development.
- Training institutions should incorporate GPC and inter professional teamwork competencies into relevant professional curricula and postgraduate training. Training should include practical case conferences rather than classroom instruction alone.
- Policymakers should strengthen policy and financing mechanisms that recognise palliative care, including GPC, as an integral component of tertiary and community health services. Funding mechanisms should support essential medicines, staffing, communication infrastructure and outreach.
- Palliative-care organisations should support the development of national or institutional minimum standards for MDT composition, communication, documentation, family engagement and quality improvement, building on African palliative-care standards.
- Staff wellbeing systems should include structured debriefing, peer support, counselling pathways and other feasible burnout-prevention mechanisms. The evidence indicates that workforce sustainability is inseparable from service sustainability.
- Digital health development should prioritize practical, context-appropriate communication systems. Electronic records, tele consultation and secure mobile communication can strengthen information sharing, but implementation should be aligned with local infrastructure rather than assumed to be universally available.
- Future researchers should undertake longitudinal multi-centre studies using validated patient, caregiver and system outcome measures. Future work should also examine how specific MDT reforms affect symptom control, family satisfaction, continuity of care, staff wellbeing and service efficiency.

A. Contribution to Knowledge

- The study makes five principal contributions. First, the study provides a comparative multi-institutional account of GPC MDT practice across ABUTH, UCH and UNTH, thereby moving beyond single-centre descriptions.
- Second, the study demonstrates empirically that structural similarity does not necessarily produce functional similarity. The absence of statistically significant differences in selected MDT distributions coexists with meaningful qualitative differences in leadership, communication, participation and institutional maturity.
- Third, the study identifies the distinction between nominal shared decision-making and experienced decision-making authority. This provides a more nuanced understanding of professional hierarchy within Nigerian MDTs.
- Fourth, the study extends the application of Parsons' AGIL framework to GPC by showing how resource scarcity, integration failures, workforce strain and goal attainment are interconnected within health-service organizations.
- Fifth, the study contributes a context-sensitive health-services perspective in which professional capacity, cultural responsiveness, institutional support and resource conditions are treated as interconnected determinants of MDT effectiveness. This has particular relevance to social work because holistic GPC requires attention to social

circumstances, family systems, psychosocial distress and access to resources alongside biomedical care.

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