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ARE MULTI-DISCIPLINARY TEAMS A LEGAL SHIELD OR JUST A CLINCAL COMFORT BLANKET?

Abstract

Discussion and management of patients through Multi-disciplinary team meetings (MDMs) has become the standard of care in medical and surgical specialties, but do they provide a legal shield for clinicians? (Names deleted to retain anonymity) discuss the legal implications of decision-making within an MDT.

KEYWORDS

Multi-disciplinary team; law; legal; accountability; documentation

Introduction

Multidisciplinary team (MDT) meetings are widely established in the NHS and have been endorsed by the Department of Health, (1) allowing allied health professionals to jointly manage, in particular, complex patients(1.5). Although helping with clinical decision-making, this approach raises questions about where liability falls should a patient come to harm from an MDT decision, the primary clinician or the MDT collectively. Further, could the MDT itself form a 'legal' shield, if the patient's clinical management is challenged? Globally, as medicine becomes increasingly litigious, these turn into pertinent considerations (16).

The clinical effectiveness of the MDT

The clinical effectiveness of the MDT has been consistently demonstrated in many areas of both medicine and surgery(2, 3); improving clinical outcomes for patients with heart failure(4, 5), chronic respiratory disease(6) and hip fractures(7-9) to name but a few. Although others have suggested the clinical impact of MDMs is limited and the scarce resources would be best deployed elsewhere (10-11). In particular, in areas where management is complex and multifactorial, there is a particular benefit from a multispecialty approach, for example, reducing amputation rates in patients with diabetic vascular disease(12). MDT is synonymous with superior diagnostic and management decisions(13) in patients with newly diagnosed cancer along with improvements in overall survival(2, 14) therefore unsurprisingly, the NHS

Cancer Plan(14) dictates MDT engagement. However, this national decree fails to give guidance at how the MDT as an entity should be set-up or administered.

Clearly without an open and tension free forum, the patient safety may be compromised if over bearing individuals cause the MDT to become dysfunctional (16).

What the GMC says

As the governing body, there is an encouragement for practitioners to seek advice from their colleagues, which by implication fosters the MDT approach, even at an informal level. The seeking of advice of other health professionals is particularly important when there is need of greater experience or a different specialism (17). The question is where does the responsibility for that decision lie, as by definition, the person asking the question has a limited ability to evaluate the advice, hence why they are seeking more information, but ultimately they may shoulder the responsibility for that decision if challenged at a later date due to harm being caused.

Current guidance emphasises the importance of clear and relevant communication between teams and identifying any problems from unclear responsibilities. When applied to the MDT, this translates to setting out the role of each member from the outset, therefore laying a framework for shared responsibility. In practice however this is rarely undertaken. Ultimately, the primary doctor's actions will be reviewed, with their GMC registration put at risk in the event of an adverse patient outcome, irrespective of the MDT decision, however, by involving other specialists it is likely to provide an extra layer of safety netting. The GMC also states that doctors are not accountable to the GMC for the decisions and actions of other clinicians(17), however, the primary clinician retains a level of responsibility in providing correct and sufficient information to allow an informed MDT decision to be made and also in assessing the patient, implementing a management plan and communicating with the patient.

What the law says

In medical law, responsibility is given to individuals and not to groups, practical and evidently easier to establish. There is little reported or published surrounding who the responsibility for such group decisions may rest upon(18). Similarly, there is little to be found in negligence proceedings that involve MDTs rather than individual clinicians. However, given litigation is increasing annually in the UK(19), medicolegal actions will inevitably examine decisions in which MDTs are involved in making.

Most medical jurisdictions run on a fault based system. The essential question is whether the clinical actions have fallen below the standard of care expected. In order for damages to be recovered, the patient has to establish that there was a duty of care, a breach of that duty and damage flowing directly from that breach (19). Examining these three factors in an MDT context:

i. **Was there a duty of care?** This 'duty' arises from the professional patient-doctor relationship that is formed initially through consultations, written information and even teleconferencing(20). When a patient is referred to the MDT, this generates a dynamic relationship based upon high quality information, imaging and anaesthetic assessments even if the patient never meets the members of the MDT. There can be little doubt that the MDT as a whole owes a duty of care, therefore the question is this a collective responsibility or does this remain with the patient's clinician?

ii. **Was the duty breached?** At a superficial level a doctor is not negligent if there is another responsible body of medical opinion that would have acted in the same way as the treating clinician. Thus, does the MDT act as a shield in this instance as it is a consensus opinion from a group of experts, therefore making the collective opinion protective should the management be challenged in the future. The test applied would be the same, however, it would be more difficult for an injured patient to suggest that a 10 member MDT decision was defective, than a single clinician.

This is in the same light as using clinical guidelines produced by bodies such as NICE, which now allows judges to have objective benchmarks of practice for comparison. It is harder for doctors to defend an alleged breach of duty that is contrary to recommendations from such external agencies. Doctors consulting MDTs must consider the implications and justification for deviating from an MDT plan and must provide clear documentation of their logical reasoning for doing so. If significant changes are made post MDT discussion it is worth relaying this back or re-discussing, in order to rely on the collective wisdom if the clinician decision is challenged.

iii. **Were the damages caused as a result of that breach?** This would be down to expert evidence of where the breach of duty lead directly to the damage caused and would not be influenced by the nature of the original clinical decision(21).

Accountability of the MDT and each member

The MDT has no official legal identity unlike a corporation or a statutory body. It has been argued that the group decision is considered to have been made on the basis of individual opinions of the doctors present at the meeting(22). Following this logic the following propositions would apply to the allied health professional attending the meeting:

i. They do not need to meet the patient or overtly contribute to the discussion to attract a duty of care and hence legal responsibility.

ii. Individuals could only be held responsible for the part of a decision that was within their area of expertise: medical cardiologists attending a coronary artery bypass surgery MDM would not be held responsible for the surgical approach agreed upon by their surgical colleagues.

iii. The soundness of the decision relies on all the relevant information being placed before the MDT. It is the responsibility of the primary clinician to ensure all relevant clinical information is provided at the meeting and is accurate. Only then can informed decisions be made based on these comprehensive facts about the patient's medical history and results of their diagnostic tests(23). There is stronger grounding should there be any adverse outcome from this decision, compared if information was later discovered to be inaccurate. Furthermore, clear documentation makes the decision easier to be relied upon in the future when memories of the discussion have faded. A UK national postal survey of surgeons assessed the recording of decisions made at breast cancer MDMs, and found that no formal procedure for recording decisions existed at 5·9% of meetings(14).

iv. The decision, along with the disagreements, needs to be explained to the patient to enable them to make an informed decision. If there is disagreement within the MDT or the referring clinician wishes to depart from the MDT conclusion, this needs to be explained to the patient. This is for two reasons; firstly, without this explanation it would invalidate the consent. Secondly, if the patient becomes aware of this discrepancy following the alleged harm of this disagreement, it is likely to fuel the litigation desire.

Litigation within different specialties and the role of MDT

A failure to use MDT at an early stage within the United States has found to be one of the main cause of successful litigation within vascular surgery (24). Given the benefit of better anatomical understanding of a surgical procedure from reviewing imaging with radiologists in MDMs and therefore the reduced risk of iatrogenic intra-operative injury, it's lack of use is difficult to defend. In complex spinal surgery, where there is a high level of damages(25), the MDT potentially gives a way of helping to justify clinical decisions if questioned later, providing the basis of the decision came from a well-informed group of specialists that had considered other options.

Conclusion

MDMs lead to improved clinical decision-making and may act as a legal shield if the MDT is provided with appropriate supporting information and clear documentation is made. The primary clinician still takes responsibility for implementing and communicating the final decision to the patient and therefore if they choose to go against the MDT decision then clear and logical reasoning should be documented to prevent legal backlash in the event of an adverse event. As in all areas of medicine medico-legal considerations need to be borne in mind but not dominate, to ensure good decisions are made rather than defensive medicine practised.

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