https://doi.org/10.60115/11055/1189

Medicolegal issues associated with multidisciplinary teams – a discussion relevant to anaesthesia and pain medicine specialists

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Edited by Associate Professor Matthew Doane

INTRODUCTION

Over the past 30 years, there has been a large increase in the number of acute and chronic medical conditions that are managed by multidisciplinary teams (MDTs), such that they are now considered the gold standard of care. Along with the development of evidence-based medicine, the MDT has enabled the development of treatment regimens according to best practice, taking into account the individual patient circumstances. Despite being commonplace and considered the gold standard, there are few guidelines as to how MDTs should be conducted. In the absence of guidelines and subsequent lack of standardisation it is difficult to determine whether an MDT is functioning effectively. In the situation of a unanimous decision regarding a treatment regimen, and an optimal treatment decision being made, there is probably little medicolegal risk to any member of an MDT. However, in the not unlikely situation when a variety of treatment options exist, and a suboptimal treatment regimen recommended, then the medicolegal risks to a member of an MDT are less clear. Pain specialists are frequently involved in MDT decision making. Anaesthetists may be of the opinion that their participation in MDTs is limited, but with an ageing population demographic, patients surviving longer with extensive co-morbidities, and the possibilities of alternative less invasive therapies, it is not surprising that the expertise of anaesthetists, particularly as perioperative physicians, will be sought in MDTs.

Increasingly, the theoretical medicolegal risks of MDT participation have been considered but have not been conclusively tested in legal proceedings.[1] In Australia and other jurisdictions, MDTs have come under increasing scrutiny in both public and private health systems. This has occurred as a result of public inquiries into suboptimal care provided without MDT input, employment law relating to participation in MDTs, regulatory body discipline determinations, and two Australian coronial inquest findings. One finding, having determined the absence of MDT decision making, highlighted the necessity for MDT involvement in patient care. While this outcome would seem to paint a clear picture of legal support for the utilisation of MDTs in similar situations, the other finding found fault and culpability in the consequences of poor communication within MDT processes.[2,3,] It is into this environment of heightened awareness and scrutiny of MDT practices that anaesthetists will be asked for their input.

When looking at an MDT process from a patient's point of view, Australian law professor Ian Freckleton AO KC writes "For the person at the centre of such a gathering, several reasonable assumptions can be made – that it is the convenor of the meeting who makes the decisions, or that all who are present, unless they explicitly voice their dissent, contribute to or at least acquiesce in the decision."[4] While MDTs are yet to feature prominently in litigation, there has been a clarification in the legal sense of doctor-patient relationships over recent years, with implications for MDT members.

In this chapter we will discuss the major medicolegal issues for MDT members relating to the existence of a duty of care and dissent from a treatment decision and consider strategies to reduce the risk from MDT participation.

THE DUTY OF CARE OF MDT MEMBERS

The relationship between a treating physician and a patient may range in a spectrum from that of the primary treating physician through to that of the Good Samaritan helping out in an emergency. The duty of care is evidently clear in the situation of an individual doctor treating an individual patient. However, tertiary, and quaternary hospitals increasingly garner input from the myriad of specialties present in an equally diverse spectrum of formality. These nuanced and sometimes complex relationships have created a chasm in quantifying how a duty of care overlays these interactions, and this assessment continues to evolve from a legal point of view, especially with the increasing use of telehealth services. This conundrum is reflected in a recent United States court judgment which stated "[i]n light of the increasing complexity of the health care system, in which patients routinely are diagnosed by pathologists or radiologists or other consulting physicians who might not ever see the patient face-to-face, it is simply unrealistic to apply a narrow definition of the physician-patient relationship in determining whether such a relationship exists..."[5] This begs the question, "what is your duty of care if you participate in an MDT"?

There are two likely scenarios in which an anaesthetist or perioperative physician may be involved in an MDT setting, the first being that of an *informal consultation*, seeking an opinion as to whether a patient may be fit for surgery, the second is that a formal request to participate in the MDT process to determine treatment, which may or may not be in the form of a *second opinion.* These relationships have now been considered and developed within legal proceedings, such that it may be assumed that a duty of care exists within the varying roles of contributors in the MDT process.

THE INFORMAL CONSULTATION

Despite being extremely common, the informal consultation is an enigma. Most medical practitioners would feel comfortable identifying an "informal consult," yet objectively defining the boundaries of what would constitute one is more vexatious. Although the term "informal consultation" is not a legal term, there are certain commonalities that appear when discussing what it is; these being that the doctor does not examine the patient, has no direct communication with the patient, does not review the patient's records, has no obligation for formal consultation, receives no payments for services, gives opinion and advice only to the primary treating physician, and that the treating physician remains in control of the patient's care and treatment.[6] These features are often seen in anaesthesia practice, when a proceduralist may seek an opinion as to whether a patient may be "fit" for anaesthesia, or the optimal type of anaesthesia. They also may describe the way an anaesthetist may be consulted by an MDT as to whether a patient may be fit for a proposed treatment regimen. Both these situations may occur in a less formalised way within private or independent healthcare systems.

Traditionally, courts have tended to view an informal consultation as one colleague providing a service to another, enabling the provision of better healthcare, and that the informal consultations typically did not result in a formal relationship between the consulted doctor and physician. Courts have however noted that doctors consulted "have professional and ethical obligations to act with the skill, knowledge, and diligence commonly expected in their field of specialty."[6]

Given the more litigious environment of the United States, it is not surprising that this is where legal developments and precedents may originate. A recent court decision has looked at the informal consultation from a new perspective. Rather than looking at an expressed physician-patient relationship for a finding of medical negligence, this judgement has considered the foreseeability of harm.[7] This was considered from two perspectives. Firstly, in this type of consultation (informal consultation) a doctor owed patients a duty of care because their advice may expose a patient to danger if their advice was acted on, and the doctor was bound to know that the patient would be likely to follow that advice. Secondly, that when a doctor provides medical advice and it is foreseeable that another party will rely on that advice, a duty of care therefore exists. It would not be unreasonable to speculate that even with the advice that a treating practitioner may receive from an informal consultation, that a patient would be likely to follow this advice when it is presented by a treating practitioner with whom they are already likely to have an express relationship.

As argued above, it would be reasonable to consider that in any legal process for negligence, the nature of the informal consultation could be considered to describe a practitioner's participation in an MDT.

THE SECOND OPINION CONSULTATION

What constitutes a (clinical) second opinion differs according to the expectation of that opinion for both practitioners and their patients, and within jurisdictions. Within an MDT process, the more traditional expectation of a second opinion is applicable. This describes a situation in which "a treating doctor asks a patient to see a colleague so that the two doctors can discuss the case with the aim of allowing the treating doctor to better understand the case and its significant aspects. Therefore, a second opinion is provided to and for the treating doctor, to help their assessment and formulation of a treatment plan."[8]

It could be considered within certain MDT frameworks, especially those that are becoming more streamlined and protocol managed, that the role of the MDT members is to provide a second opinion, from which to confirm a diagnosis and treatment, having considered the information that has been prepared according to protocol. Although this may appear similar to the informal consultation role, the second opinion role occurs in a much more formalised and structured process.

There are relatively few legal cases relating to doctors who have provided a second opinion. This may be because a second opinion is almost always considered a beneficial process, as alternative treatments may be considered. Particularly in the case of an MDT, a clinician may be able to offer a new perspective or rein in potentially bullish treatment options that may be affected by human factors, such as unconscious bias, by the primary treating doctor.

An early case looking at the role of the second opinion was from New South Wales in 1980.[9] In this case, a consultant orthopaedic surgeon requested a second opinion from a consultant neurosurgeon for the management of a spinal condition. As the treatment had already commenced, the neurosurgeon elected to review the patient later in the admission. By the time of this review, the patient had suffered irreversible neurological damage and had become a paraplegic. The court determined that although the neurosurgeon had not seen the patient, they should have been aware of the possibility of spinal cord damage, and that the potential for this damage would depend on their advice.

The judgement stated that:

> "…it could be concluded that he [the neurosurgeon] knew and accepted that the question of the possible danger to the patient's cord would be to some extent dependent on his advice; and this factor alone, in my view, imposed a duty on him. She became, for relevant purposes, his patient…. Even though he had only been consulted for a second opinion, had not initiated the treatment, and had not been primarily responsible for the care of the patient…[the court] held that the neurosurgeon had a duty of care to the patient."

The three key elements in this judgment that may be relevant to MDT members is that: firstly members are consulted because of their expertise, secondly there may be seen to be a failure to intervene to prevent damage, and thirdly that, although the surgeon in this case was only consulted for a second opinion and was not the primary treating practitioner, a duty of care was found to have still existed.

CONSENT AND INFORMATION SHARING IN MDT PROCESSES

Karas et al propose that there are four conditions which need to be met for a person to give informed consent for their disease to be considered by an MDT.

1. That the patient of interest (or carer) understands the purpose of the MDT meeting.
2. That this patient is aware of the disciplines that may participate.
3. The patient is informed about those who in the MDT process will be present in an observational capacity.
4. The patient is informed about what data from their medical history will be shared.

However, for any doctor to make an informed treatment decision, they reasonably require a patient's more complete medical history. For this reason, consideration should be given to adding a fifth condition, that patients should be informed about the breadth of their medical history that will be provided and that needs to be considered by the MDT, and why this information is necessary.

A specialist, in this case an anaesthetist, will be aware of the points in a history that would be considered relevant to their decision making, but it may be that these salient points are not considered within an MDT process prior to an anaesthetist being involved in decision making. Without access to an anaesthetist-patient consultation, it is not feasible for an anaesthetist to have all relevant information and examination findings available for decision making without a formal consultation having taken place prior. This is relevant in the potential for liability, which will be discussed below.

DISSENT AMONG MDT MEMBERS, AND DOCUMENTATION OF DISSENT

Casarett writes that it is "unrealistic to expect that health care professionals will always agree about which plan of care is best. It is essential, though, that they discuss their differences openly."[10] Despite the negative connotations of the word, dissent is common, but it is not necessarily harmful: it has the potential to improve health outcomes. Martin proposes a model for the search for truth in medicine, using the concepts of a unitary or plurality of truths, and whether the search occurs by conflict, as shown (with examples suggest by the writers of this chapter) in the table below.[11]

Table 1: Unitary truth versus plurality of truths in the context of conflict and cooperation.

	Cooperation	Conflict
Unitary truth	Cooperative search for truth and social benefit *e.g., Non-surgical treatment for single vessel coronary disease*	Orthodoxy versus dissent/heresy *e.g., HIV is the virus that causes AIDS versus HIV does not cause AIDS*
Plurality of truths	Cooperative tolerance *e.g., Haemodialysis versus peritoneal dialysis for renal failure*	Competition; market struggle. *e.g., Different varicose vein treatments (as they are not covered by public health)*

One of the reasons MDTs were instituted was that there was a plurality of truths to treat certain disease processes, and that no single practitioner would be able to make an optimal treatment decision. It is extremely unlikely that any dissent in an MDT would be by conflict against a unitary truth; instead, it almost certainly will be based upon considered thought and review of the evidence base of medical science as to the best application of therapies to a patient. In this situation, the purpose of dissent is neither malicious nor resulting from professional jealousy; its purpose is in seeking the best possible patient care. Karas et al note that disagreements or dissents in the workings of MDTs are related to three main areas. Firstly, the uncertainties in the evidence base for more complex cases can lead to multiple potential treatments being reasonably appropriate. Secondly, differing beliefs surrounding the technical/treatment feasibility between practitioners. Thirdly, inadequate awareness and consideration of the patient's wishes.[12] With increasing respect for patient autonomy, this third area should (ideally) diminish as a necessary cause of dissent.

It is possible to classify dissent into major and minor dissents. From an anaesthetic point of view, an example of a major dissent may be over whether a patient is fit enough for renal transplant to justify the risks of anaesthesia and the potential loss of a donor organ should there be an adverse anaesthetic outcome. A theoretical example of a minor dissent could be whether a patient should be delayed for curative surgery for a malignant neoplastic disease in the presence of an asymptomatic infection (for example, COVID-19) that was coincidentally detected on a standard screening examination. Regardless of the type of dissent, both are likely to be in the presence of a plurality of truths, and it is important that differing opinions are documented. One reason for documentation of even minor dissent is that this opinion is (potentially) able to be communicated to a patient/carer. This may appear difficult to implement, given the number of minor dissents. To the healthcare professional, the relevance or significance of minor dissent may be trivial, as the long-term outcomes of the disease process are unlikely to differ significantly, but in the eyes of the patient or their family members, these alternative treatments may be significant, especially to patients from certain religious and cultural backgrounds.[13]

The purposes of documentation of dissent are two-fold. The first is ethical, in respecting patient autonomy for decision making, allowing them to be fully informed as part of an informed consent process. The second reason is to provide a framework for the legal protection of the MDT members in a situation where the proposed treatment plan results in unexpected complications or a sub-optimal patient outcome and the MDT process is called into question.

Health professionals who contribute to treatment recommendations within an MDT meeting share responsibility for the decisions made at such meetings, within their area of expertise, and could be potentially liable if a negligence case is brought by a patient.[1] If an MDT member feels that they are being asked to weigh in on decisions that are outside of their area of expertise, it is appropriate that a member abstain from engagement in these areas, and ensure that this abstention is documented and clarified in meeting summaries. Unless there is documented dissent or abstention, it could be argued that all participants are directly involved in and supportive of a patient's care.

FAILURES OF THE MDT PROCESS, AND REDUCTION OF ASSOCIATED MEDICOLEGAL RISKS

Despite the best efforts of all members involved, there will be occasions when the process will fail, and MDT members should consider these points to minimise their medicolegal risks. The main areas by which an MDT process may fail can be classified as follows:

1. Decisions made, based on incorrect or incomplete presentation of information to the MDT. In the case of any doubt, MDT members should always seek further information or clarification prior to decision making.
2. Decisions made on information that has been withheld from the MDT by a patient or a healthcare professional. Despite adequate informed consent processes, some patients may be unwilling to fully disclose their complete medical histories. Ensuring that all available information is documented in patient and meeting summaries is important to reduce risk.
3. Decisions made on the basis of incorrect opinions from MDT members. The onus is on all team members to ensure that their opinions are based on up-to-date evidence-based practices. Once again, an MDT member should ensure that their dissention is clearly recorded if they disagree with the proposed treatment regimen, or their abstention if they believe a decision requested is outside their area of expertise.
4. Failure to continually assess treatment regimens implemented by MDTs. Medical therapies may evolve rapidly, as may patient co-morbidities, side effects, and complications of treatment. It is important that any clinician treating a patient according to a regimen proposed by an MDT, reports back to the MDT regarding progress or issues relating to treatment. These changes likely require frequent re-assessment by the MDT and may require changes to treatment recommendations.
5. Failure of correct documentation and communication. The Craig inquest[3] highlighted issues relating to documentation standards in MDT processes and made a formal recommendation that MDT notes should be taken by a suitably experienced clinician or health practitioner, or where this is not possible, notes should be checked by a suitably experienced clinician prior to being circulated. Within Australia, there exists a national project to ensure that coronial findings and recommendations from one jurisdiction are made known to other jurisdictions.[14] It is not unreasonable to expect that, having been highlighted in one jurisdiction, the issues and common legal pitfalls will become more readily apparent to both courts and healthcare practitioners. With this increasing scrutiny, MDT members would be advised to review notes and summaries from meetings they participate in, to ensure that they are complete and accurately reflect the conduct and decision making for both patient outcomes and legal proceedings.

CONCLUSION

In an editorial on patient expectations and the legal liability of MDTs, Freckleton chillingly notes that "(l)aw, as delivered by the civil courts and the regulatory authorities, is a blunt instrument for enhancing the quality of health service provision and bringing about behaviour change."[4] The reality, however, is that the civil courts and regulatory authorities only come into play when the behaviour of the practitioner or the functioning of a healthcare system results in patient outcomes that do not meet expectations of society. Since that time, MDT processes have been examined in multiple legal cases and inquiries, and process changes initiated. The development and continued increasing use of MDTs means that the MDT is not likely to be replaced anytime in the near future in health care systems; in all probability it will become more complex as the scientific understanding of disease processes increases. It is only by being proactive in identifying and acting upon the legal risks of the MDT processes that practitioners will be protected from appearances before the civil courts and regulatory authorities, and more importantly, patients will receive the best possible outcomes in the management of their diseases.

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