

## Can liability rules keep pace with best practice? The case of multidisciplinary cancer care

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*The main objectives of medical negligence law relate to substandard care — the direction the law will take when new treatment approaches come along is not always clear*

If two heads are better than one, then four should be much better, and six should be truly formidable. The axiom is especially likely to hold true when the problem at hand is multifaceted, and each head carries knowledge that is relevant, different, and complementary. Therein lies the allure of multidisciplinary care (MDC) teams in cancer care.

An age has passed since any surgeon, radiologist, pathologist, radiation oncologist, medical oncologist, or general practitioner could legitimately claim to be working both in splendid isolation and safely. Consultation among clinicians is integral to modern medical care. But the physical meeting of so large and diverse a group of busy clinicians, together with their allied health colleagues, for purposes of devising treatment plans for individual patients is a relatively recent phenomenon. Twenty years ago, the notion would surely have been met with disbelief in many hospitals. Today, the growing complexity of cancer treatment, coupled with new knowledge about the promise of team-based management in health care,<sup>1,2</sup> are quickly establishing MDC teams as a standard feature of high-quality cancer care.

Evidence of the effect of MDC on quality of care is still emerging. Recent studies suggest that cancer patients managed through MDC teams may have better decisions made about their care,<sup>3</sup> live longer,<sup>4</sup> enjoy better quality of life during treatment,<sup>5</sup> and receive services more efficiently.<sup>6</sup> However, substantial gaps remain in understanding the impact of MDC.<sup>7-9</sup>

From a medicolegal perspective, the salient aspect of MDC is that it shifts aspects of clinical decision making away from single actors and toward groups. How will courts handle allegations of substandard decision making levelled at all members of the team, or the team itself? Will team members with second-hand knowledge of the patient's condition assume less responsibility for faulty plans than those directly involved in the patient's care? What of members who opposed the care path chosen? And what obligations do hospitals have to ensure MDC teams are established and that they play a meaningful role in clinical decision making?

The short answer to these questions is that we don't know yet. The absence of negligence claims targeting MDC in Australian courts and Anglo-American jurisdictions abroad means that we must speculate (although it is surely just a matter of time before litigation on point materialises).

A threshold question in any negligence claim is whether the wrongdoer owed a duty of care to the person wronged. In medical negligence claims, the defendant's duty is rarely disputed. In fact, tort law textbooks present the patient–doctor relationship as a paradigmatic example of a dutiful relationship. Occasionally, however, the assumption is challenged. Telemedicine<sup>10</sup> and supervision of trainees by senior doctors at a distance<sup>11</sup> are two recent examples of circumstances that force close consideration of the contours of the patient–doctor relationship. In both situations, duties may be imposed, even when the defendant clinician works at a considerable remove from the injured patient.

The wise course is for each member of an MDC team to assume that, by virtue of their involvement in a team meeting, they assume certain responsibilities to the patient. (Indeed, responsibilities arise in virtually any setting in which doctors turn their mind to a particular patient and give advice.) Fulfilling those responsibilities requires sound judgement and informed input, commensurate with what would be expected of a team member's professional peers were one of them seated at the same table and presented with the same information.

If the first step in a medicolegal analysis of MDC is to recognise that the team and its members may be exposed to liability for their activities, the second step is sober assessment of how large that exposure is, and what can be done to minimise it. In this vein, the article by Evans and colleagues in this issue of the *Journal* (page 401)<sup>12</sup> is a welcome addition to the literature. The authors outline consensus recommendations developed at a workshop of experts. Their suggestions are clear and useful, particularly the need for attention to MDC activities in the informed consent process and careful documentation of team membership and resolutions.

To these, I would add a simple exhortation to participants in MDC team meetings. Speak up! Your professional responsibilities entail weighing in wherever your expertise is relevant. If information is insufficient to render an informed opinion, say so. Group consensus is helpful, and learned clinical colleagues acting in good faith will often arrive at it, but, as Sidhom and Poulsen point out, MDC meetings should not be regarded as a strictly democratic process in which majorities rule.<sup>13</sup> Disgruntled wallflower is the wrong part to play in an MDC team.

Standards of care in medical negligence law are fluid and progressive. Today's cutting-edge treatment may become a routine and expected treatment in the future, as it diffuses through clinical practice and evidence of its efficacy mounts. A curious aspect of negligence law is that novel treatments or approaches to care tend to raise heightened liability risks in their innovation phase, but once they gain currency, the risk profile flips: failure not to employ them becomes the greater liability risk.

Recognition of this legal reality brings special resonance to the investigation of the uptake of MDC approaches among breast surgeons by Marsh and colleagues in this issue of the *Journal* (page 385).<sup>14</sup> Standards of care are not defined purely by reference to the prevalence of particular practices in the medical community; nor are recommendations and guidelines from august professional bodies, such as the National Breast Cancer Centre, accepted as definitive proof as to whether a particular practice has become an accepted standard. On the other hand, both factors are highly relevant considerations in determining the applicable standard of care.

In Australia today, at least in some settings, MDC has probably become the standard of care for treatment of some cancers, particularly breast cancer. For other cancers, it likely stands on the cusp of becoming so. Thus, Marsh and colleagues' findings<sup>14</sup> should grab

the attention of administrators and practitioners working in hospitals that have not adopted MDC practices. Rural and private facilities appear particularly likely to be in this situation.

Many rural and private hospitals will face barriers to MDC that their counterparts in urban and public settings do not, as the article's authors point out.<sup>14</sup> Standards of care can bend to accommodate unavoidable resource and manpower constraints. However, in institutions where an MDC approach is feasible but is not being pursued, hospital leaders should carefully review their position. It is conceivable that a claimant may allege that the appropriate approach for breast cancer treatment was not followed and that, had it been, the harm in question would not have occurred. Such accusations would be likely to fall particularly heavily on the institution itself for failing to organise for effective MDC.

Success for the plaintiff in this type of claim will not be easy. The evidence that MDC systematically improves quality of cancer care remains quite thin,<sup>7-9</sup> which makes proving that it would have done so in an individual case an uphill climb. Nonetheless, it is quite possible that litigation along these lines may be brought. In that event, defendant institutions will no doubt find the attendant publicity unsavoury, whatever the claim's outcome.

The law aims to promote high-quality care, not retard it. Legal doctrine is neither static nor vacuum-sealed. As practices change, and promising initiatives like MDC emerge, the law must evolve to accommodate them, without abandoning its commitment to holding providers accountable for substandard care. Timely scholarship, like the articles in this issue of the Journal,<sup>12,14</sup> can help guide that evolution at the right pace and in the right direction.

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