

# Medicolegal implications of a multidisciplinary approach to cancer care: consensus recommendations from a national workshop

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Multidisciplinary care has become incorporated into national and state and territory clinical practice guidelines, frameworks and plans across Australia as a model for best practice in cancer care.<sup>1-8</sup> A central focus for multidisciplinary teams is the treatment planning meeting, in which health professionals from medical and allied health disciplines jointly discuss a patient's case and recommend a treatment plan. Not all attendees will be involved in the patient's care, raising questions about who could be liable if a patient suffered harm as a consequence of the agreed treatment and brought a negligence case in relation to their care.<sup>9</sup> The need for clarification about medicolegal implications of multidisciplinary care was highlighted in 2006, during a national forum series in which clinicians identified confusion in this area as a potential barrier to implementing multidisciplinary care.<sup>10</sup> Issues around which clarification was needed included:

- approaches to patient consent before a multidisciplinary meeting;
- professional liability implications of team-based decisions compared with individual practitioner recommendations; and
- documentation of meeting outcomes.<sup>10</sup>

The need for guidance in this area was increased with the introduction, in November 2006, of new Medicare Benefits Schedule (MBS) item numbers for specialists participating in multidisciplinary treatment planning meetings.<sup>11</sup> This move raised the question of whether clinicians' liability is influenced if they charge patients for their attendance at a multidisciplinary meeting.

Providing guidance for health professionals and health services in relation to such issues requires consideration of both legal and ethical principles. Legal precedent in this area is limited. In 2004, a New South Wales administrative tribunal ruled that privacy principles were breached by a health service when information about a patient's psychological history was shared with clinicians involved in the management of her cancer without her consent.<sup>12</sup> We are not aware of any case in Australia or overseas in which negligence proceedings have been brought against a multidisciplinary team rather than individual clinicians or hospitals. However, given the perceptions of health professionals about medicolegal risk, it may be useful for health professionals and health services to have appropriate guidance on which to base their practice.

In 2007, a workshop of clinical, legal and ethical experts was held by the National Breast Cancer Centre (renamed the National Breast and Ovarian Cancer Centre in February 2008) to develop consensus advice in this area, with the aim of achieving best outcomes for patients, while also providing appropriate guidance for health professionals and health services (Box 1).

## Consensus recommendations

Workshop participants considered a number of medicolegal and ethical issues related to multidisciplinary care. Questions relating to patient consent and professional liability were discussed first by a panel of clinical, legal and ethical experts, and consumers to provide an overview of the main viewpoints. Each issue was then

## ABSTRACT

- Concerns about medicolegal implications of a multidisciplinary approach to cancer care may act as a barrier to the implementation of best practice approaches.
- While multidisciplinary meetings carry a low level of medicolegal risk, improved documentation and transparency in approach will assist in limiting liability for individual health professionals and health services.
- The medicolegal implications of a multidisciplinary approach are not affected by whether a health professional bills the patient for attendance at multidisciplinary meetings.

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For editorial comment, see page 380. See also page 385

### 1 Workshop format and attendees

Attendees included representatives from national and state government bodies, cancer organisations, professional colleges, and consumer groups, as well as lawyers and ethical experts. The workshop was facilitated by New South Wales Court of Appeal judge, the Honourable Justice Margaret Beazley AO. The interactive program included expert panel discussion, small group work and facilitated group discussion to agree appropriate guidance for health professionals and the services in which they work.

Attendees included representatives of the following organisations:

- The Australian Medical Association
- Breast Cancer Network Australia
- Cancer Australia
- Cancer Nurses Society of Australia
- Cancer Institute NSW
- Cancer Voices Australia
- Centre for Values, Ethics and the Law in Medicine
- Clinical Excellence Commission (NSW)
- Clinical Oncological Society of Australia
- Australian Government Department of Health and Ageing
- Department of Human Services (Victoria)
- Medical Oncology Group of Australia
- Slater & Gordon, Lawyers
- The Royal Australian College of General Practitioners
- The Royal Australasian College of Surgeons
- The Royal College of Pathologists of Australasia
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- The Royal Australian and New Zealand College of Radiologists
- Avant Mutual Group Limited

considered by small multidisciplinary groups who proposed one or more recommendation(s) for refinement by the full group. Follow-up with legal experts after the workshop allowed further refinement of the recommendations in line with legal principles. Central to the debate was the need to maintain best patient outcomes as the key guiding principle, and to minimise the likelihood that perceptions of medicolegal risk become a barrier to implementing multidisciplinary models of care.

The consensus recommendations generated at the workshop (Box 2) emphasise the importance of good communication with patients and between team members, improving documentation and ensuring transparency in the processes that support multidisciplinary care. Clinicians can be reassured that these recommendations do not differ significantly from risk advice given in other areas of practice. While implementing these recommendations may have resource implications, it was agreed that the use of generic proformas and templates could help minimise the workload.

**Documentation of team role and function**

Adequate documentation of the role and membership of the team, and of protocols guiding team function was viewed as an essential component of risk management. In practice, this means documenting team membership, including the “core” disciplines integral to treatment planning for the relevant cancer type(s) and other disciplines that may be relevant to some, but not all cases. Given that there is no single standard approach to multidisciplinary meetings, the purpose of the meeting should also be defined and documented. The importance of a protocol for attendance at meetings by non-clinical members was emphasised, giving consideration to whether it is appropriate for some non-clinical members to be present during case discussions. For example, it was recommended that while representatives from pharmaceutical companies may address meeting attendees during the meeting, they should not be present for case discussions.

An ongoing question for multidisciplinary teams is which patients should be discussed at a multidisciplinary meeting.<sup>11,13</sup> It was recommended that teams should document the criteria used to determine which cases will be discussed and, if the team determines that a referred case need not be discussed, then the decision and reasons should be documented in the patient record.

**Patient privacy and consent**

Privacy of patient health information was identified as a key issue when considering referral of a patient's case to a multidisciplinary planning meeting.<sup>14</sup> It was agreed that patient consent should be obtained before such a referral takes place, regardless of whether patients will be billed by clinicians for the case discussion.

Informed patient consent requires that patients understand the purpose of the multidisciplinary meeting, the disciplines that may participate in discussions, those who may be present in an observational capacity, and what information about their health and medical history, including psychosocial history, will be shared with the team. A generic patient information sheet can assist with this process. It was recommended that patients should be given time to consider whether they consent to having their case discussed, and should have the opportunity to ask questions or identify any information they do not wish to be shared. The process of gaining consent before the meeting is the responsibility of the treating clinician, although this task may be delegated to

**2 Summary of consensus recommendations**

- Team purpose, membership and roles should be documented.
- Criteria for attendance by non-clinical members should be agreed and documented.
- Criteria for which patients are discussed should be agreed and documented.
- Informed patient consent should be obtained and documented in the patient record before discussing a case at a multidisciplinary meeting.
- Patients do not need to be de-identified during multidisciplinary team discussions.
- Health professionals who contribute to a treatment recommendation within a multidisciplinary meeting share responsibility for the decisions made at such meetings within their area of expertise, and could be liable if a negligence case is brought by a patient.
- Health professional liability is not influenced by whether the patient is charged for the professional's attendance at the multidisciplinary meeting.
- The treating clinician is responsible for ensuring that all relevant information relating to the patient's case is presented during the multidisciplinary meeting.
- Dissenting views about a recommended approach to treatment should be recorded in the treatment plan.
- The treating clinician is responsible for communicating the treatment recommendation(s) to the patient.
- The final treatment plan, incorporating any changes due to patient preference, should be recorded in the patient record and communicated to the patient's general practitioner. ♦

another member of the team. According to the criteria for billing MBS items 871 and 872, where the patient will be billed for meeting attendance by one or more clinicians, they must be informed in advance of the meeting that a charge will be incurred.<sup>10</sup> While patient consent may be written or verbal, according to local protocols, the fact that consent has been given should be documented in the patient record.

**Identification of patients in meetings**

Concern about patient privacy prompted discussion about the identification of patients within a multidisciplinary team setting. Patients discussed during multidisciplinary meetings are protected by the same principles of doctor–patient confidentiality as occurs in an individual consultation. It was deemed unnecessary to de-identify patients during multidisciplinary team discussions. In practice this means that patients can be identified in the meeting by, for example, name or initials and date of birth. It was recommended that members of the multidisciplinary team should have the option to declare a conflict of interest and to opt out of decision making (eg, in circumstances where the patient is known personally to the team member).

**Professional liability**

It was agreed that health professionals who participate in multidisciplinary team meetings carry responsibility for their actions within that team, akin to other clinical responsibilities, regardless of whether the patient is billed for the services of that professional. Health professionals who contribute to a treatment recommendation within a multidisciplinary care meeting share responsibility

for the decisions made at such meetings. It is apparent in an individual consultation that a duty of care arises when there is a professional relationship between a doctor and patient. However, the shift towards a team approach means that a doctor–patient relationship, and as a result, a duty of care, may arise even though there may be no personal contact with the patient.<sup>9</sup> For example, a medical oncologist may contribute to a discussion about an appropriate course of chemotherapy being managed by a colleague at a different hospital. Regardless of whether a face-to-face interaction takes place, input to a treatment recommendation represents a formal relationship and, as such, the contributing doctor is liable for the advice provided to the patient. Responsibility is shared within the health professional's area of expertise. It was agreed that the use of the MBS item numbers allowing clinicians to bill patients for their attendance at a multidisciplinary meeting does not affect the clinician's potential liability. Non-participating team members who are present in an observational capacity for a case discussion should not share responsibility for the recommendation. With these principles in mind, it was recommended that, for each case discussed, the identity (name and discipline) of team members who contributed to the discussion and decision making is recorded.

As team members can only make proper decisions based on information that is provided to the meeting, it is essential that accurate and comprehensive information about the patient's relevant medical history and the results of diagnostic tests are available.<sup>15</sup> It was agreed that it is the responsibility of the treating clinician to ensure that all relevant and accurate patient information is available and presented. If an opinion from a discipline considered essential to formulation of the treatment plan for a patient is not available during the meeting, referral outside the team meeting should occur before a treatment plan is recommended.

Given that more than one treatment option may be appropriate for a patient, it was recommended that team members who disagree with a proposed recommendation, or who have an alternative recommendation, should raise this during the meeting and dissenting views should be documented as part of the treatment plan. To facilitate this process, the meeting chair or lead clinician should provide a summary at the end of each case discussion to confirm consensus or provide an opportunity for final comments and dissenting views to be raised. The recommended treatment plan should be documented and included in the patient record. If more than one option is recommended, or if there are dissenting views about the course of treatment to be recommended, this should be documented in the treatment plan and communicated to the patient.

It was agreed that outcomes from multidisciplinary meetings are recommendations or options to be discussed with the patient by the treating clinician. The recommended treatment plan should not be implemented until the patient has agreed to a course of action and after appropriate counselling that complies with contemporary standards of patient disclosure. It was recommended that it is the responsibility of the treating clinician to ensure that such a discussion takes place, and that it includes details of the proposed treatment plan, risks and benefits of the proposed treatment, and possible alternatives. The final treatment plan agreed to by the patient should be documented in the patient record and communicated to the patient's general practitioner and other relevant treating clinicians, and should include details of any

changes due to patient preference. Proformas to record meeting attendance, document the treatment plan and communicate the treatment plan to the general practitioner may assist in streamlining this process.

It seems likely that the risk of adverse patient outcomes, complaints and claims derives principally from treatment plans wrongly formulated because of inadequate or incorrect information provided to the multidisciplinary team (inputs) or treatment plans wrongly communicated to patients and their clinicians (outputs). For this reason, the crucial importance of good communication, systems and tools to support the process cannot be overemphasised.

## Conclusions

As multidisciplinary care becomes established as best practice for the management of patients with cancer, the number of designated teams is increasing. There is little precedent on which to base recommendations about the medicolegal and ethical implications of a team approach to care, suggesting that such a team approach carries only a low level of medicolegal risk. Concerns by individual team members or health services about the potential for litigation should not serve as a barrier to multidisciplinary care. Adequate documentation of processes should not only limit liability for individual health professionals, but is likely to improve team practice and encourage best outcomes for patients. While the introduction of greater levels of documentation may be seen as a challenge for health professionals working in a time-poor and resource-poor environment, the use of proformas and templates should help to streamline these approaches.

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## Competing interests

None identified.

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