

Medicolegal Considerations in Multidisciplinary Lung Cancer Care

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Background

Clinical practice frameworks across Australia now incorporate multidisciplinary team (MDT) care as a model for best practice cancer management¹.

There is evidence for improved outcomes from MDT care compared with "non-MDT" care including

- Being more likely to receive anticancer treatment²
- Longer survival^{2, 3, 4}
- Better treatment receipt, which may improve quality of life⁵

Despite this, concerns about the medicolegal implications of MDT care may act as a barrier to implementation including:

- (1) patient consent before an MDT meeting;
- (2) professional liability in team-based decisions compared with individual practitioner recommendations; and
- (3) documentation of meeting outcomes.

Currently, there is limited precedent on which to base recommendations.

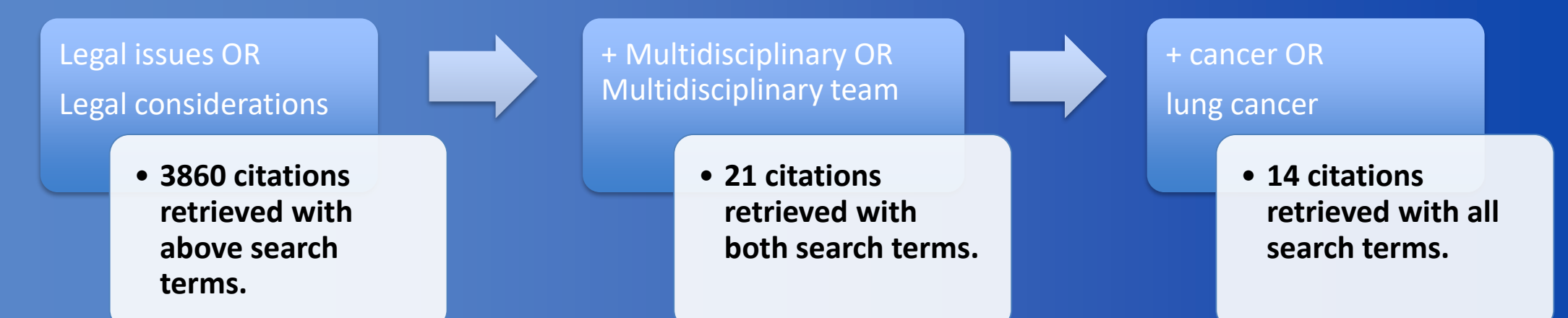
Objectives & Methods

Objectives

To identify the key medicolegal issues concerning the MDT approach to cancer as well as review the literature recommendations for managing these.

Method

- Relevant papers were identified from a search of the the medical literature in the PubMed database using the following terms:



- Eleven papers were finally reviewed based on relevance to the study aims and analysed for medicolegal issues related to MDT care.

Results - Medicolegal Issues Identified

1. Patient Consent and Privacy

Three papers addressed the issues of consent and privacy.

One paper (Connolly 2004) discussed a case in which a NSW 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 consent⁶.

An audit of 51 MDTs across a range of tumour streams (breast, gynaecological, lung, prostate and colorectal) found that one-third of patients were not informed their case would be discussed by the MDT and patient consent was not sought for half of all cases discussed⁷.

A consensus statement from a national workshop proposed that patients discussed at MDM are protected by the same principles governing doctor-patient confidentiality as occurs in individual consultations¹. It recommended the following to ensure appropriate consent:

- Patient consent should always be obtained before a referral to the MDM takes place, regardless of whether the patient will be billed by clinicians for case discussion.
- Informed consent requires that;
 - (a) patients understand the purpose of the MDM,
 - (b) they are aware of the disciplines that may participate,
 - (c) those who will be present in an observational capacity,
 - (d) what information about their medical history will be shared.
- It is the responsibility of the treating clinician, although may be delegated to another team member.

Recommendations

Informed consent should be obtained (verbal or written) and documented in the patient record before discussion at a MDM

Patients do not need to be de-identified during MDT discussions.

2. Professional Liability

Five papers addressed the issue of professional liability.

One paper discussed the fact that an MDM group has no official legal identity that itself can act, and hence attract, liability for any negligence. This raised the question of who would be liable if a patient suffered harm because of an agreed decision⁸.

Sharpe (2000) suggested that any group decision must be considered to have been made based on individual opinions of the doctor's present and thus, doctors attending the MDM are deemed to have been personally consulted about the patient⁹.

A survey of 18 MDMs in four Australian tertiary-case hospitals demonstrated that doctors in MDMs may not completely appreciate their legal responsibilities and potential liability generated against their involvement¹⁰. Only 48% of doctors believed they were individually liable for decisions made by the MDM.

The above study also indicated that even though 85% of doctors disagreed with the final MDM decision at some time, 71% did not formally dissent on those occasions¹⁰.

A French study revealed that disagreements were most often related to; (a) lack of answers in the Evidence-Based Medicine for more complex case leading to multiple potential treatments, (b) different interpretations of technical feasibility amongst surgeons, and (c) a lack of consideration of the patient's wishes¹¹.

A consensus from a national workshop proposed the following to clarify professional responsibility in MDM decision-making¹:

- The meeting chair should provide a summary at the end of each case discussion to confirm the consensus or provide an opportunity for final comments and dissenting views
- The recommended treatment plan should be relayed to the patient and not be implemented until the patient has agreed. The final treatment plan, including any changes due to patient preference, should be recorded in the patient record and communicated with the patient's General Practitioner.

Recommendations

Those who contribute to treatment recommendations share responsibility for the decisions within their area of expertise, and could be liable if a negligence case is brought by a patient.

Dissenting views about a recommended approach to treatment should be recorded in the treatment plan

3. Duty of Care

Three papers addressed the issue of duty of care.

One paper (Olick & Bergus, 2003) discussed that through a formal referral process, the consulted doctor assumes a duty of care to the patient¹². The court considers the following when determining whether a referral is formal:

- a) the existence of a written referral,
- b) the extent of the information given to the specialist,
- c) the awareness of the patient about the referral,
- d) whether the advice will generally be relied on,
- e) whether the referral and subsequent advice are documented, and
- f) whether the specialist is paid for the consultation.

If these are fulfilled, then the consulted doctor owes a duty of care to the patient; a failure to provide careful advice renders that doctor liable to direct action in negligence brought by the patient¹².

Sidhom & Poulsen (2006) suggest that all doctors present at an MDM would be deemed to owe a duty of care to the patients discussed⁸. This duty of care arises when the treating physician refers the patient to the MDM doctors. Most oncology MDMs would be regarded as a formal referral process that gives rise of a duty of care.

A consensus statement from a national workshop proposed that all doctors participating in MDMs should be aware that they owe a duty of care to all patients that are discussed, despite no personal contact with the patient¹.

Note that the non-participating members present in an observational capacity should not share the duty of care responsibility for recommendations made¹.

Recommendations

For each case discussed, members of the MDM who contribute to the treatment plan and decision making process should be identified and recorded, as they have a duty of care to the patient and may be held legally responsible for decisions made within their field.

The final treatment plan, incorporating any changes due to patient preference, should be recorded in the patient record and communicated with the patient's General Practitioner.

Conclusions

1. Australian doctors participating in MDTs may not completely understand their medicolegal obligations.
2. With limited precedent on which to base recommendations, this review serves to identify formative evidence that may guide management of these issues in future MDT practice.

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