# Are multidisciplinary teams a legal shield or just a clinical comfort blanket?


## ABSTRACT

Discussion about and management of patients through multidisciplinary team meetings has become the standard of care in medical and surgical specialties, but does the team nature of these provide a legal shield for clinicians? This article discusses the legal implications of decision making within a multidisciplinary team.


Multidisciplinary team meetings are widely established in the NHS and have been endorsed by the Department of Health, (Raine et al, 2014), allowing health-care professionals to jointly manage, in particular, complex patients (Garcia-Aymerich et al, 2007; Raine et al, 2014). Although this helps with clinical decision making, this approach raises questions about where the liability falls should a patient come to harm as a result of a multidisciplinary team decision – with the primary clinician or the multidisciplinary team collectively. Further, could the multidisciplinary team itself form a 'legal' shield, if the patient's clinical management is challenged? Globally, as medicine becomes increasingly litigious, these turn into pertinent considerations [Al-Mishlab v Milton Keynes Hospital NHS Foundation Trust 2015].

## The clinical effectiveness of the multidisciplinary team

The clinical effectiveness of the multidisciplinary team has been consistently demonstrated in many areas of both medicine and surgery (Taylor et al, 2010; Department of Health, 2011), improving clinical outcomes for patients with heart failure (Ducharme et al, 2005), chronic respiratory disease (Casas et al, 2006; Garcia-Aymerich et al, 2007) and hip fractures (Stenvall et al, 2007a,b; Pedersen et al, 2008) to name but a few. However, others have suggested that the clinical impact of multidisciplinary teams is limited and the scarce resources would be best deployed elsewhere (Mullan et al, 2014; Ryan and Faragher, 2014). 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 (Rubio et al, 2014). The multidisciplinary team is synonymous with superior diagnostic and management decisions (Kurpad et al, 2011) in patients with newly diagnosed cancer along with improvements in overall survival (Fleissig et al, 2006; Taylor et al, 2010), so unsurprisingly, the NHS Cancer Plan (Department of Health, 2000) dictates multidisciplinary team engagement. However, this national decree fails to give guidance as to how the multidisciplinary team as an entity should be set up or administered.

Clearly without an open and tension-free forum, patient safety may be compromised if over-bearing individuals cause the multidisciplinary team to become dysfunctional [Al-Mishlab v Milton Keynes Hospital NHS Foundation Trust 2015].

## What the General Medical Council says

As the governing body, practitioners are encouraged to seek advice from their colleagues, which by implication fosters the multidisciplinary team approach, even at an informal level. Seeking advice from other health professionals is particularly important when there is the need for greater experience or a different specialism (General Medical Council, 2013). The question is where the responsibility for that decision lies, as by definition, the person asking the question has a limited ability to evaluate the advice, hence why he/she is seeking more information, but ultimately he/she may shoulder the responsibility for that decision if challenged at a later date as a result of harm being caused.

*Good Medical Practice* (General Medical Council, 2013) emphasizes the importance of clear and relevant communication between teams and identifying any problems from unclear responsibilities. When applied to the multidisciplinary team, 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 his/her General Medical Council registration put at risk in the event of an adverse patient outcome, irrespective of the multidisciplinary team decision, although involving other specialists is likely to provide an extra level of safety. The General Medical Council also states that doctors are not accountable to the council for the decisions and actions of other clinicians (General Medical Council, 2013), but the primary clinician retains a level of


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responsibility in providing correct and sufficient information to allow an informed multidisciplinary team 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, which is practical and evidently easier to establish. There is little reported or published surrounding who the responsibility for such group decisions may rest upon (Sidhom and Poulsen, 2006). Similarly, there is little to be found in negligence proceedings that involve multidisciplinary teams rather than individual clinicians. However, as litigation is increasing annually in the UK (Gulati et al, 2012), medicolegal actions will inevitably examine decisions which multidisciplinary teams were 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 (Gulati et al, 2012). Examining these three factors in the context of a multidisciplinary team:

### 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 (Brahams, 1995). When a patient is referred to the multidisciplinary team, this generates a dynamic relationship based upon high quality information, imaging and anaesthetic assessments even if the patient never meets the members of the multidisciplinary team. There can be little doubt that the multidisciplinary team as a whole owes a duty of care, so the question is whether this is a collective responsibility or whether this remains with the patient's clinician?

### 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 multidisciplinary team 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, but it would be more difficult for an injured patient to suggest that a 10-member multidisciplinary team decision was defective than that of a single clinician.

This is in the same light as using clinical guidelines produced by bodies such as the National Institute for Health and Care Excellence, 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 multidisciplinary teams must consider the implications and justification for deviating from a multidisciplinary team plan and must provide clear documentation of their logical reasoning for doing so. If significant changes are made post-multidisciplinary team discussion it is worth relaying this back or re-discussing, in order to rely on the collective wisdom if the clinical decision is challenged.

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### 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 (Hurwitz, 2004).

## Accountability of the multidisciplinary team and each member

The multidisciplinary team 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 (Sharpe, 2000). Following this logic the following propositions would apply to the health-care professional attending the meeting:

1. The health-care professional does not need to meet the patient or overtly contribute to the discussion to attract a duty of care and hence legal responsibility.
2. 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 multidisciplinary team meeting would not be held responsible for the surgical approach agreed upon by their surgical colleagues.
3. The soundness of the decision relies on all the relevant information being placed before the multidisciplinary team. 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 diagnostic tests (Blazeby et al, 2006). There is stronger grounding should there be any adverse outcome from this decision than 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 multidisciplinary team meetings, and found that no formal procedure for recording decisions existed at 5–9% of meetings (Fleissig et al, 2006).
4. The decision, along with any disagreements, needs to be explained to the patient to enable him/her to make an informed decision. If there is disagreement within the multidisciplinary team or the referring clinician wishes to depart from the multidisciplinary team conclusion, this needs to be explained to the patient. This is for two reasons; first, without this explanation it would invalidate the consent. Second, if the patient becomes aware of this disagreement following any alleged harm, it is likely to fuel the desire for litigation.

## KEY POINTS

- A health-care professional does not need to meet the patient or overtly contribute to the discussion to attract a duty of care and hence legal responsibility.
- Individuals can only be held responsible for the part of a decision that is within their area of expertise.
- It is the responsibility of the primary clinician to ensure all relevant clinical information is provided at the meeting and is accurate.
- The decision, along with any disagreements, needs to be explained to the patient to enable him/her to make an informed decision.

## Litigation within different specialties and the role of the multidisciplinary team

A failure to use a multidisciplinary team at an early stage is one of the main cause of successful litigation within vascular surgery in the UK (Markides et al, 2008). Given the benefit of better anatomical understanding of a surgical procedure from reviewing imaging with radiologists in multidisciplinary team meetings and therefore the reduced risk of iatrogenic intraoperative injury, its lack of use is difficult to defend. In complex spinal surgery, where there is a high level of damages (Quraishi et al, 2012), the multidisciplinary team meeting 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.

## Conclusions

Multidisciplinary team meetings lead to improved clinical decision making and may act as a legal shield if the multidisciplinary team is provided with appropriate supporting information and decisions and discussions clearly documented. The primary clinician still takes responsibility for implementing and communicating the final decision to the patient and therefore if he/she chose to go against the multidisciplinary team 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 medicolegal considerations need to be borne in mind but not dominate, to ensure good decisions are made rather than defensive medicine practised. **BJHM**

*Conflict of interest: none.*


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