



Multidisciplinary care – what are the medicolegal implications?

Report from a plenary symposium held at the 34th Annual Scientific
Meeting of the Clinical Oncological Society of Australia

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**NATIONAL BREAST
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CANCER CENTRE**

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Multidisciplinary care: what are the medico-legal implications?

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Panel

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Associate Professor Annette Braunack-Mayer

Mr Jim Kollias

Mr Bill Madden

Dr Mark Sidhom

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BACKGROUND

Clinical practice guidelines and national and state/territory cancer frameworks and plans acknowledge that multidisciplinary care represents best practice in the care of patients with cancer.¹⁻⁸ National Breast and Ovarian Cancer Centre (NBOCC) has conducted a range of national initiatives to encourage the implementation of multidisciplinary care for all cancers. In 2005–6, a national forum series conducted by the National Breast Cancer Centre (NBCC)* identified concerns about medico-legal implications of a team approach to cancer planning and treatment as a potential barrier to the implementation of multidisciplinary care.⁹ The introduction in November 2006 of Medicare Benefits Schedule (MBS) items to reimburse specialists for their attendance at multidisciplinary treatment planning meetings¹⁰ added further impetus to the need for guidance in this area, with anecdotal feedback from health professionals indicating concern that billing a patient for attendance at a multidisciplinary treatment planning meeting could increase their medico-legal risk.

In March 2007, NBCC convened a workshop of medical, legal and ethical experts as well as consumer and government representatives to develop consensus advice about the potential medico-legal implications of a multidisciplinary approach to cancer care.¹¹

Recommendations from the workshop covered a range of areas including:

- team role and function
- patient consent (including financial consent)
- identification of patients in team meetings
- implications of a team approach to treatment planning on professional liability of health professionals
- impact of claiming MBS items for multidisciplinary meeting attendance on professional liability.

Overall, the workshop concluded that, while legal precedent in the area is limited, participation in multidisciplinary treatment planning meetings carries a low level of medico-legal risk for health professionals. A central theme of the workshop was the need to ensure best patient outcomes. The recommendations focused on the need for improved communication within the team and between health professionals and their patients, improved documentation and strengthened processes to support multidisciplinary care.

NBCC held a plenary symposium at the 34th Annual Scientific Meeting of the Clinical Oncological Society of Australia (COSA) in November 2007 to provide an opportunity for broader dissemination of these consensus recommendations and to explore some of the practical implications in more detail with an expert panel.

**In February 2008, National Breast Cancer Centre (NBCC) changed its name to National Breast and Ovarian Cancer Centre (NBOCC).*

OVERVIEW

The 1.5-hour plenary symposium comprised an expert panel discussion facilitated by Dr Megan Keaney, Chair of the NBOCC Board of Directors and Head of Claims for the NSW branch of the medical defence organisation Avant.

Panel members were:

- Associate Professor Fran Boyle – Medical oncologist, Mater Hospital NSW
- Associate Professor Annette Braunack-Mayer – Lecturer in Ethics, University of Adelaide SA
- Mr Bill Madden – Solicitor, Slater & Gordon, NSW
- Mr Jim Kollias – Surgeon and Head of the Breast Section, Royal Australasian College of Surgeons SA
- Dr Mark Sidhom – Radiation oncology registrar and law graduate NSW
- Mr John Stubbs – Executive Officer, Cancer Voices Australia, NSW.

To provide context for the panel discussion, Dr Helen Zorbas (Director, NBOCC) opened the symposium with a short presentation outlining the work undertaken by NBOCC to support multidisciplinary cancer care since 2000 and an overview of outcomes from the March 2007 workshop.

PANEL DISCUSSION

The expert panel discussion focused around a hypothetical case study involving the development of a multidisciplinary treatment plan for a breast cancer patient. The case study is provided in Table 1. The case study was designed to highlight potential issues related to medico-legal aspects of multidisciplinary care. Panel members were asked to identify and explore these issues in relation to the recommendations made at the March 2007 workshop, with a view to providing practical guidance about the implementation of the recommendations. An overview of the panel discussion in relation to the case is provided below, together with key recommendations from the March 2007 workshop. An updated and refined list of recommendations is provided at the end of this report.

Table 1: Hypothetical case study: Jane Smith*

Clinical history	56-year-old female Post-menopausal Current medications: Prozac Presented to GP with a lump Mass at 3 o'clock in the right breast
Diagnosis	GP sends Jane for mammography and ultrasound – suspicious mass identified; core biopsy performed – pathology confirms invasive ductal carcinoma; referral to a breast surgeon and wide local excision performed with sentinel node biopsy.
Pre-multidisciplinary meeting	Surgeon visits Jane post-surgery in recovery and tells Jane that he will discuss her case with some colleagues to decide what further treatment is needed and that he will see her in his rooms next week.
Multidisciplinary meeting	Jane's case is presented to a multidisciplinary meeting at a large teaching hospital. Meeting attendees include surgeons, medical oncologists, radiation oncologists, a radiologist, pathologist, breast care nurse, registrars, oncology nurses, medical students, breast physicians and a genetic counsellor. Pathology shows a 1.8mm positive invasive ductal carcinoma, with DCIS extending close to the inferior margin; the carcinoma is grade 2 and ER & PR positive; HER2 status is unknown (pathology missing); 1 of 3 sentinel nodes is positive. Jane's case is presented by the treating surgeon who provides a brief overview of her medical history, including psychosocial issues. The ultrasound images are available to view at the meeting but the mammogram images are missing and not presented. There is much discussion about the case, with some debate about the need for further surgery. The treating surgeon indicates that he feels the surgery was adequate and that he will tell the patient this. Systemic therapy is not determined.
Post-multidisciplinary meeting	The treating surgeon sees Jane at his rooms the following week and tells her "We've got it all" and that she will be referred to a radiation oncologist.

*This is a hypothetical case study. Any resemblance to actual persons is purely coincidental.

COMMUNICATION WITH THE PATIENT

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- Informed patient consent should be obtained before a patient's case is discussed by the multidisciplinary team.
- Informed consent should be obtained regardless of whether the patient will be billed by clinicians for the case discussion.
- Patients should understand what they are consenting to, the composition of the multidisciplinary team (including non-participatory members) and what information will be shared with team members.
- Patients should have the opportunity to identify any information they do not wish to be shared with the team.
- Patient consent can be verbal or written according to local protocols but should be documented in the patient record.

PANEL VIEWS

The panel identified that communication with the patient in the case study presented was inadequate, both in terms of the level of information provided to the patient and the inappropriate timing of the discussion.

Panel members highlighted a number of issues relating to the importance of adequate communication between the treating clinician and patient in advance of the multidisciplinary meeting, including:

- ensuring that communication with the patient about the treatment planning process is conducted at an appropriate time and place
- providing an adequate level of information to the patient about the format and purpose of the multidisciplinary meeting, including who is likely to be in the meeting, the nature of the discussion, potential outcomes and who will discuss the meeting outcomes with the patient after the meeting
- ensuring that the patient provides informed consent for their case to be discussed (written or verbal consent according to local protocols)
- consideration of the patient's right to refuse to have their case, or aspects of their case, discussed during the multidisciplinary meeting
- the importance of keeping a record of the team discussion and for this to form part of the patient record that is accessible by the patient if required.

It was recommended that all team members should consider themselves responsible for appropriate communication with the patient and that the team can decide who is best placed to communicate information about the team and its processes with the patient. It was agreed that a discussion with the patient about the team approach to cancer care and treatment planning should be held as soon as possible after a definitive diagnosis of cancer.

IDENTIFICATION OF PATIENTS DURING MEETINGS

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- It is unnecessary to de-identify patients during multidisciplinary team discussions.

PANEL VIEWS

Panel members agreed that the majority of patients are not concerned about privacy in this context and would be happy to be identified during multidisciplinary meetings as long as the aim and purpose of the meeting had been explained to them. It was noted, however, that a minority of patients may not wish to be identified during the meeting. A related issue was the importance of de-identification of patients if there are attendees present in an observational capacity other than health professionals and students. It is important to note that in the March 2007 workshop, attendees strongly recommended that pharmaceutical representatives should not be present during case discussions.

AVAILABILITY OF ADEQUATE INFORMATION

As background to this discussion, Dr Mark Sidhom provided an overview of a survey he conducted to elicit clinician views about medico-legal issues relating to multidisciplinary care in which 70% of clinicians identified that inadequately worked up patients were the single limiting factor in a well-functioning team.¹³ Some respondents indicated that in such instances, a patient may be deferred for presentation at a later meeting, or that decisions may be made based on assumptions or recalled information.

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- An accurate and comprehensive presentation of the patient's medical history and diagnostic tests should be provided at the multidisciplinary meeting.
- If an opinion from a discipline considered essential to the treatment of a patient is not available during the meeting, referral outside the team meeting should occur before a treatment plan is recommended.

PANEL VIEWS

The panel identified that it was unacceptable that information was not available at the treatment planning meeting in the case study.

Panel members agreed that it was essential that all relevant information is available during the treatment planning meeting. In circumstances in which additional work up is required after the meeting to determine the definitive treatment plan, the treating clinician is responsible for communicating with the other team members after the meeting to inform them of the results.

Panel members also discussed the range of information that may be presented at a multidisciplinary meeting, in light of results from a 2004 NSW Administrative Tribunal, which 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.¹⁴ It was agreed that patients should understand what is involved in a multidisciplinary meeting and what information may be discussed.

Members suggested that if a patient requests that information be withheld from the team, it will be important to consider whether the information is relevant to the treatment recommendation. If withholding the information could affect the treatment outcome, it is the responsibility of the treating clinician to explain this to the patient, and to document the patient's request if they remain adamant about their decision.

PROFESSIONAL INDEMNITY

As background, Dr Sidhom presented results from his survey, which indicated that around 50% of clinicians did not feel that they were legally responsible for discussions at multidisciplinary meetings unless they were directly involved with the patient's care after the meeting.¹³

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- Health professionals who contribute to a treatment recommendation in a multidisciplinary team meeting share responsibility for that recommendation within their area of expertise, even though they may have no personal contact with patients whose cases are discussed.
- Non-participating team members who are present in an observational capacity for a particular case discussion do not share responsibility for the recommendation.

PANEL VIEWS

Panel members agreed that those health professionals who are involved in developing recommendations for a patient's treatment plan could be held responsible in the case of a patient grievance. However, non-participatory meeting attendees would not be legally responsible for decisions made during the meeting.

In the case of a patient grievance, the first point of contact would be the health professional who has management responsibility for the patient. If there was then sufficient evidence to suggest that the treatment recommendation was made by a team and that the team recommendation diverged from best practice, the team may then be liable. If the issue was that a treatment decision was made on the basis of missing or incorrect information, then the health professional responsible for presenting the case could be found negligent.

MEETING FACILITATION

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- The meeting chair or lead clinician should provide a summary/overview at the end of each case discussion to confirm consensus or provide an opportunity for final comments to be raised.

PANEL VIEWS

Panel members identified that in the case study, it was not helpful for the treating surgeon to also chair the meeting, as decisions were made without the full input of the team.

The need for appropriate facilitation of multidisciplinary team discussions was a central feature of the panel discussion, with suggestions for good facilitation including the need to check with all team members about their views, and avoidance of dominance of meetings by one or two key members. It was suggested that it can be helpful for meetings to be facilitated by a team member who is not directly involved in the treatment planning process, allowing the treating clinicians to focus on the case and providing greater opportunity for inclusion of all relevant views.

CONFLICTING VIEWS

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- Team members who disagree with a proposed recommendation or who have an alternative recommendation should raise this during the meeting and this should be documented.

PANEL VIEWS

Panel members discussed the issue of conflicting views during multidisciplinary meetings. It was agreed that rather than conflicting or dissenting views, it was more common to have several treatment options presented. In such instances the options should be documented and conveyed to the patient. The treating clinician may decide to recommend one course of action but should acknowledge that other suggestions were made. In rare circumstances it may be that the team view was different to the treating clinician's view. In such circumstances, it would again be the responsibility of the treating clinician to inform the patient of this fact and for the treatment alternatives to be documented. Members agreed that multidisciplinary teams do not have to achieve consensus on every aspect of the patient's care but that it is important that appropriate referrals for further work up or care should be made during the meeting.

A central theme in this discussion was the importance of maintaining patient trust by being clear about the treatment options available and supporting patients to make appropriate decisions.

CHANGES TO TREATMENT PLANS AFTER THE MEETING

NBCC RECOMMENDATIONS (MARCH 2007)¹²

- 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, including details of any changes due to patient preference.

PANEL VIEWS

Panel members identified that in the case study, the lack of information about the HER2 status of the patient meant that a decision about systemic treatment could not be made during the meeting and would require further discussion outside the meeting.

Panel members were asked to consider what should happen if a consensus approach is reached during the meeting but as a result of either patient preference or the availability of new information, a different approach is later taken. It was agreed that in order to ensure continuity of care, it is important for all health professionals who were present at the original multidisciplinary meeting and are involved with the patient's care to be kept informed of changes to the treatment plan until a definitive treatment plan has been decided.

It was noted that a patient may decide not to go ahead with the treatment recommendations made by a team. In such circumstances, it is important to document the change to the treatment plan in the patient's medical record. If the patient chooses a course of treatment that is not in line with best practice, a second opinion may be offered to further discuss the benefits of the recommended approach.

Panel members also discussed what should happen if, after discussing the treatment recommendations, a patient requests treatment not in line with standard care. Members agreed that patients should not be given dangerous or inappropriate treatments, but that if the treatment requested is one for which there is some evidence of benefit, the patient's right should be respected and the decision documented.

USE OF GUIDELINES

Panel members were asked to consider how clinical practice guidelines are used during meetings and what would happen if a treatment plan made during a team meeting is at variance with a best practice guideline. From a legal perspective, it was suggested that minor deviations from guidelines do not need to be discussed with a patient but that if there is a significant variation from the guideline or if the treatment recommended is experimental, the team has a duty to discuss this fully with the patient. Members agreed that if there is a significant deviation, the treating clinician should explain the rationale to the patient, in a manner that the patient can understand. The involvement in team meetings of all disciplines relevant to good patient care will help to ensure that all relevant aspects of care are considered.

PRIVATE PRACTITIONERS

Panel members were asked to consider what documentation should be kept in relation to multidisciplinary team discussions by private practitioners who attend a public hospital team meeting. It was suggested that private practitioners should keep their own records of patients discussed during meetings, even if that information is not recorded in the medical record. Information can then be added to the patient's file if treatment is given in the private system.

SUMMARY

The plenary symposium held during the COSA 2007 meeting aligned closely with the outcomes from the NBCC March 2007 workshop, and provided some practical examples of how the consensus recommendations can be implemented. It was agreed that a fundamental goal of multidisciplinary meetings should be to provide comprehensive best practice recommendations for patient care. Participation by health professionals in a multidisciplinary treatment planning meeting is associated with a low level of medico-legal risk. Implementation of standardised and transparent approaches to documentation and communication represents the most effective approach to limit professional liability and encourage best outcomes.

NBOCC will continue to promote a multidisciplinary approach to cancer care by disseminating and promoting these recommendations and developing new resources to support multidisciplinary treatment planning meetings.

RECOMMENDATIONS

Table 2 provides an updated list of recommendations about medico-legal aspects of multidisciplinary care based on outcomes from the NBCC March 2007 workshop and the November 2007 COSA plenary symposium.

Table 2: National Breast and Ovarian Cancer Centre recommendations about medico-legal aspects of multidisciplinary meetings for cancer treatment planning

Aspect of approach	Recommendations
Team role and function	<ul style="list-style-type: none"> • The membership of the team and the purpose of the multidisciplinary meeting should be defined and documented in each clinic or hospital. • The protocols and criteria used by the multidisciplinary team should be transparent.
Communication with the patient	<ul style="list-style-type: none"> • Informed patient consent should be obtained before a patient's case is discussed by the multidisciplinary team, regardless of whether the patient will be billed by clinicians for the case discussion. • Informed patient consent should be obtained at an appropriate time and place. • Patients should understand the purpose and composition of the multidisciplinary team (including non-participatory members), what information will be shared with team members, potential meeting outcomes and who will discuss outcomes with them after the meeting. • Patients should have the opportunity to identify any information they do not wish to be shared with the team. • Patient consent can be verbal or written according to local protocols but should be documented in the patient record. • It is the responsibility of the treating clinician to discuss the meeting outcomes with the patient and to provide adequate counselling regarding the risks and benefits of treatment and possible alternatives.
Identification of patients during meetings	<ul style="list-style-type: none"> • It is unnecessary to de-identify patients during multidisciplinary team discussions.
Availability of adequate information	<ul style="list-style-type: none"> • An accurate and comprehensive presentation of the patient's medical history and diagnostic tests should be provided at the multidisciplinary meeting. • It is the responsibility of the treating clinician to ensure that all relevant and accurate patient information is available and presented at the multidisciplinary meeting. • If an opinion from a discipline considered essential to the

	<p>treatment of a patient or an additional test result is not available during the meeting, referral outside the team meeting should occur before a treatment plan is recommended.</p> <ul style="list-style-type: none"> • Where additional test results are required after a multidisciplinary meeting, it is the responsibility of the treating clinician to inform other team members of the results.
Professional indemnity	<ul style="list-style-type: none"> • Health professionals who contribute to a treatment recommendation in a multidisciplinary team meeting share responsibility for that recommendation within their area of expertise, even though individual health professionals may have no personal contact with patients whose cases are discussed. • Non-participating team members who are present in an observational capacity for a particular case discussion do not share responsibility for the recommendation. • The use of MBS item numbers allowing clinicians to bill patients for their attendance at a multidisciplinary meeting does not affect the clinician's potential liability.
Meeting facilitation	<ul style="list-style-type: none"> • The meeting chair or lead clinician should provide a summary/overview at the end of each case discussion to confirm consensus or provide an opportunity for final comments to be raised. • Facilitation of meetings by a team member who is not directly involved in the treatment planning process may encourage inclusion of all relevant views.
Alternative views	<ul style="list-style-type: none"> • Team members who have an alternative treatment recommendation to that proposed in a meeting should raise this during the meeting. • Alternative treatment options should be documented and conveyed to the patient.
Changes to treatment plans after the meeting	<ul style="list-style-type: none"> • 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, including details of any changes due to patient preference or further results. .
Use of clinical practice guidelines	<ul style="list-style-type: none"> • Where a treatment recommendation varies significantly from the best practice guideline, the treating clinician has a duty to discuss this fully with the patient, including the rationale for the variation.

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