

Border areas in head and neck pathologies: professional liability in the multidisciplinary approach

Implicazioni medico-legali nel trattamento delle patologie di confine della testa e del collo

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SUMMARY

Discussing border areas in Head and Neck pathologies means addressing diseases' convergence point of different specialities and professionalisms guided by a common goal: patient health. Starting from the concept of a border, it becomes possible to define the content of a new model of team responsibility: no longer that of the team leader who, as a new Agamemnon, takes on the role of scapegoat when things go wrong, even for errors not directly attributable to his supervision, but that of a *primus inter pares*, a King Arthur with the Knights of the Round Table, committed like the others, each with his wealth of experience and knowledge, to pursue the same goal. A member of this team assumes the role of spokesperson for diagnostic and therapeutic solutions within a process of acquiring consent that recovers the dimension of verbal and non-verbal communication with the patient. In such a context, in which criminal liability can be challenging to identify based on the principle of *in dubio pro reo* and civil liability in some countries has already transferred the burden of compensation from the professional to the healthcare facility. In most, no-fault compensation systems appear consistent.

KEY WORDS: medical malpractice, multidisciplinary approach, professional liability, team liability, otorhinolaryngology

RIASSUNTO

Discutere di zone confine nelle patologie del distretto testa-collo significa affrontare il tema di quelle malattie che costituiscono il punto di convergenza di specialità e professionalità differenti guidate da un obiettivo comune: la salute del paziente. Muovendo dal concetto di confine, diviene possibile definire il contenuto di un nuovo modello della responsabilità di équipe: non più quello del team leader che, novello Agamemnone, assume il ruolo di capro espiatorio quando le cose vanno male anche per errori non direttamente riconducibili al suo operato, ma quello di un primus inter pares, di un Re Artù con i Cavalieri della Tavola Rotonda, impegnato lui al pari degli altri, ciascuno con il proprio bagaglio di esperienze e conoscenze, a perseguire lo stesso obiettivo. Un componente di questo team assume il ruolo di portavoce delle soluzioni diagnostico-terapeutiche all'interno di un processo di acquisizione del consenso che recuperi la dimensione della comunicazione verbale e non verbale con il paziente. In un siffatto contesto, in cui la responsabilità penale può essere di difficile individuazione in base al principio dell' "in dubio pro reo" e la responsabilità civile in alcuni paesi ha già provveduto a trasferire il peso del risarcimento dal professionista alla struttura sanitaria, la soluzione più coerente appare quella propria dei sistemi di no fault compensation.

PAROLE CHIAVE: colpa medica, patologie di confine, responsabilità professionale, responsabilità di équipe, otorinolaringoiatria

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Introduction: contents and limits of the concept of “border”

The first book of Rome’s history, Titus Livy, tells the legend of Rome’s founding and the epic fratricidal clash between Romulus and Remus. It narrates the tale of Remus being killed by Romulus because he dared to climb in mockery a furrow ploughed by his brother, who later entrusted his memory to posterity with the following epitaph: “So from now on, it will happen to anyone else who will pass through my walls”. Centuries later the Swiss philosopher Rousseau wrote, “The first who, having fenced off a land, dared to say, ‘This is mine’, and who found people so naïve as to believe him, was the true founder of civil society”. Therefore, the concept of border is associated with the concept of property, but this only a part of it. The Romans coined the word *limes* to refer to the frontier – to the final edge not to be crossed so as not to incur dangers that are difficult to manage. For Emperor Augustus, the *limes* is Teutoburg. In 9 AD, the defeat of Varus’ legions at the hands of rebellious Germanic tribes led by the traitor Arminius, once an officer of the Roman auxiliaries but in fact, a leader of the Cherusci insurgents caused Caesar Octavian such despair that he advised his successor Tiberius not to extend the borders of the empire and to stay inside the *limes*.

As reported in the Encyclopedia Britannica, the Latin term *limes* was initially used in agriculture to separate fields cultivated with vineyards, which later became a symbol of the last Roman advanced outpost. The word *limes* has roots in two possible Indo-European derivation *lemmas*. The first is *lik(c)/leik(c)*, which refers to the concept of “bending, going sideways”, hence the meaning of “oblique” (and therefore, a demarcation line, which is almost never straight and clear in fields dedicated to cultivation). The second is *li*, which indicates the “flowing” of a watercourse; a damp place; rich in water (in ancient Greek: *leimon*; marsh); turbid; muddy; in a sense related to *limus*; full of filth; a place difficult to cross; marked by a bad smell emanating from decomposition or from droppings collected there ¹; and marked by fear of contracting contagious diseases, to which historians acknowledge the contribution given to the strengthening of the borders between states. In its original meaning, in the sense of *limes*, a border is not only a border between neighbouring and culturally homogeneous fields, but also represents the equivalent of a marshy terrain, in which one can become entangled because of its changing characteristics, or the evolution of a possible battleground between two or more orders that are eager to assert the right of possession or expansion.

Considering pathologies as a border territory in nosographic frameworks means addressing the issue of diseases that attack a complex of well-defined organs located within a well-defined area of the body and attract the interests of different disciplines. The discussion on these pathologies and the responsibilities of caregivers cannot be traced back to the usual interpretative schemes that are appropriate for criminal and civil doctrine on health liability. Instead, they deserve to be addressed using new instruments modelled on recent legislative contributions. This was first done in the United Kingdom, followed by France and Italy, to extend the *limes* of medical action while avoiding exacerbating its pitfalls.

Pathologies as a border territory in head and neck surgery: new horizons and new and old dilemmas

If we wanted to search for the progenitor of the concept of the pathologies as a border territory, it could perhaps be useful to turn to the notion of focal pathology. The notion is clearly a didactic reference that is helpful in underlining the general influence of local disease. This is precisely the case of a focal odontostomatogenic disease, which affects a single dental element, yet its effects reverberate elsewhere toward other medical areas, such as nephrology, cardiology, neurology, and otorhinolaryngology. This is also the case with tonsillitis and its long-term repercussions, such as nephrological or cardiological effects.

However, in its original meaning, the concept of focal pathology also encompasses the origin of the concept of pathology as a border territory. In the past, a focal pathology would have involved different teams of caregivers, each one acting within their respective fields and their own disciplines’ “boundaries” as rigid interpreters of the diagnostic-therapeutic schemes of their own sectors. Today, focal pathology engages the same teams with their valuable expertise but obliges them to a shared multidisciplinary approach to facilitate early diagnosis and correctly plan subsequent therapeutic processes.

The focus is not only the disease that alters the homeostasis of the organism and produces harmful effects on contiguous or even distant organs. It is also its multiplicity of expression – even if only potential – that attracts and concentrates the interests of different specialities, which have been moving into increasingly smaller anatomical limits, despite the fact that these specialities cultivate competencies that are not entirely homogeneous.

Therefore, it is becoming increasingly common a multidisciplinary approach to design and implement the best diagnostic-therapeutic strategies for different pathologies, such

as pituitary adenomas; in this specific example, the optimal planning of preoperative diagnosis, management and treatment involves a team of endocrinologists, neurosurgeons, ENT, neuro-ophthalmologists and neuroradiologists; in order to improve surgical results, minimize complications and facilitate follow-up².

In the preoperative evaluation and in the surgical management, the team members are equally important protagonists even if with different timing and approaches; but it is important underline that this cooperation and co-responsibility does not mean that no boundaries exist. On the contrary, the “boundaries” are designed by the skills and areas that one single team member would add to achieve the optimal result conform to the “personalized” solution in specific disease in a specific patient.

As in the evolution of the limes of the Roman Empire, this simply means that the substantial prohibition of Augustus to go beyond the border was followed by Hadrian’s intuition to “integrate” the *limes* (and therefore to expand its extension). In the progress of medical knowledge, the time of rigid and solitary sectors has been replaced by the concept of multidisciplinary, confrontation, and dialogue between several “performers” who all have highly qualified knowledge. These performers do not throw themselves into virtuosic “solos” but are part of an “orchestra” capable of playing at the right time and constructing music with which the strings of each individual instrument vibrate at their best.

An example of this approach can be found in the field of head and neck neoplasms. Once a battleground between potentially involved disciplines, it has become a reference model for other oncological specialities faced with the same dilemmas of optimal treatment in other anatomical-functional districts. Today, the multidisciplinary approach in the diagnostic-therapeutic strategy of head and neck tumours is considered essential and demands that surgeons, oncologists, radiotherapists, pathologists, radiologists together study the history of an individual patient and meet to offer the patient a personalized solution. It is no coincidence that several EU Member-State legislations require the participation of multidisciplinary teams (i.e., tumour boards established in referral centres) to offer different specialist skills to guarantee strategic clinical choices for patients with head and neck cancers³. Not by chance, cancer is a focal pathology. It settles in on the part of the body but involves the entire organism and requires the skills of multiple specialities, which are in constant dialogue and have the sole objective of ensuring that the patient receives coordinated, effective, and personalized care.

Which model of responsibility for the interpreters of therapeutic-diagnostic treatment in pathologies which require a multidisciplinary approach?

Antic responsibilities: from the responsibility of Agamemnon to that of King Arthur and his Knights

The modern idea of responsibility – of Kantian derivation⁴ – is to see a subject responding only to actions with a programmed and desired result, while we shun the idea of having to answer for actions that do not depend on our decision and happen in the shadow of our actions⁵. In complex organizations, such as health care facilities, the modern idea of responsibility is often put to severe tests. Patients could be damaged, and tracing the exact cause can be difficult or even impossible in many circumstances.

Homeric heroes of ancient Greece solved this problem in a radical way. The Homeric hero answered for acts not under his direct control. In addition to paying for what he did, he also pays for what was not strictly related to his intentions and actions. Agamemnon’s responsibility⁴ for having stolen the beloved Briseis from Achilles does not end with the dutiful economic compensation assured by Agamemnon himself towards Achilles, but extends to the whole Greek army, which was scattered for Achilles’ abandonment of the battlefield. Agamemnon is forced to make public amends in front of Achaeans’ assembly to bring Achilles back into battle and reverse the fate of war.

Agamemnon’s responsibility is very reminiscent of the responsibility model once attributed to the so-called team leader based on the legal principle of “non-reliance”. By virtue of his position as coordinator and the most experienced member (his *auctoritas*), the team leader must trust neither his collaborators nor other members of the team, who are reduced to the rank of mere executors of his directives. Therefore, he responds, solely, to the mistakes possibly made by them in executing his orders. This is a model that once seemed to be tailor-made for figures similar to the team leader, such as the head of a care unit (in the past called the “primary”) or as the health director of a hospital company. Such a figure’s “public” role so to speak⁶ ended up being a pole of attraction for most disparate claims and unloading forms of objective responsibility (i.e., of an organizational nature), which the hermeneutical tools of law had not been able to canalize otherwise.

The evolution of the law is the result of a very different interpretation of the concept of “team” and was borrowed from the experience of team games, which has led to the abandonment of the “non-reliance” scheme in favour of the opposite principle of “entrustment”. Within a team, each member fulfils a valuable role and participates with their own skills to

realize results. In such a scenario, the team leader must trust the skills of his collaborators (colleagues or companions, not only those belonging to the same unit or department). The leader must maintain the obligation to supervise the correctness of others' choices and conduct and, therefore, the obligation of corrective intervention in the takeover. This is especially so when the group is faced with situations of particular difficulty. However, this solution continues to be permeated by the spirit of Agamemnon's responsibility because it is still associated with the need to identify the "guilty party" for the consequences of an action. Such consequences have so many "unknown fathers", and all of them are indoctrinated within a complex organization such as that of a health facility as if it were not possible to imagine an alternative to the so-called objective responsibility that would not proceed with the inevitable identification of a scapegoat, a San Sebastian by Mantegna, who pays for all.

And yet, among the models of responsibility forged by the law of the ancients, there is one from ancient legendary tales that seem to be made specifically to define the responsibilities of multidisciplinary groups called to confront for the treatment of pathologies as a border territory and more: King Arthur and the Knights of the Round Table. The legend of King Arthur is not only a story of one man's ability to draw a sword that is stuck in the rock, but it is above all a story of the handover of responsibility from Agamemnon to a group. The Round Table is a material representation of this passage – a geometric place of plane positions equidistant from a fixed point at the centre of the plane. Every position of the geometric place is important, and each one of them would not exist without those positions. King Arthur sits at the Round Table like any other knight. Most important of all, it is not King Arthur's position but the centre of the table that makes all others equal because of its inherent equidistance to them. In a healthcare organization that aims to guarantee the safety of care, the centre position of the Round Table belongs to the patient.

Therefore, with the personalization of care, the centrality of the patient has become a new benchmark to measure and evaluate a new model of healthcare responsibility to which all team members are called upon. In this model, subjectivity (i.e. liability) is not attributed to a scapegoat once identified in the team leader or director. Instead, the healthcare organization itself is a subject that acts equally with team members.

Inapplicability of the team responsibility scheme to the "board" responsibility model: towards the end of the "team responsibility" concept?

A healthcare team can be defined as a group of several specialists and professionals who cooperate and thus contrib-

ute to the pursuit of the common goal of patient care. This multidisciplinary activity is carried out both synchronously by professionals of the same or different hierarchical levels and diachronically – i.e., in chronologically distinct but always interdependent phases. Interaction in time and space configures the rule of teamwork. The growth of specialist knowledge, technological innovation, the multiplicity of healthcare figures have caused the paradigm of the single doctor to wane ⁷.

Various definitions of teams have appeared in the literature, but the results are not entirely satisfactory. Three models of professional cooperation have been outlined: the ward team, the surgical team (or team in the strict sense), and the team in the broad sense ⁷. The first is characterized by a work team that is only apparently monodisciplinary since it is not only composed of doctors with the same specialization who work in a hierarchically organized working relationship, but also of other independent professionals, such as nurses, technicians, rehabilitation therapists, and psychologists. A surgical team involves an activity carried out synchronously by hierarchically organized health workers with different specialities and skills. Finally, the team in a broad sense corresponds to a form of multidisciplinary diachronic cooperation – i.e., not contextual ⁸.

In this context, heterogeneous and difficult-to-assimilate forms of health cooperation/interaction come together. However, beyond all these scholastic definitions, the fact remains that it is quite difficult to reconstruct the chain of decisions and to weigh the possible roles of each health-worker in the determinism of possible damage suffered by a patient. In the attempt to trace the person responsible for an action – an action produced by one or more members of a multidisciplinary team and the consequent damage – one would in fact risk being trapped in the dilemma of the "hunting pellet". In this situation, it is not clear which of the "hunters" present at a "hunting scene" can be held responsible for the mistakenly firing the lead shot extracted from a victim's body since the victim does not remember anything. From the position of the hunters and ballistics data, it is at most possible to conclude that hunter A has a 55% chance of being the shooter and hunter B has a 45% chance of being the shooter.

In criminal proceedings, the inochentism principle applies in such a dilemma. Therefore, *in dubio pro reo*, an absolute solution could be found for both hunters, given the failure to exceed the threshold of reasonable doubt calibrated on probabilistic percentages close to certainty and not oscillating around the values of the case. In civil law, the guilty principle applies, whereby *in dubio pro misero*, according to the percentage threshold assigned *a priori* to the probability of guilt, two different conclusions could be

reached: the attribution of responsibility to both hunters, albeit in a proportionate manner, or the recognition of responsibility by the person who has exceeded the limit of 50% + 1 of such probability⁹.

Just try to imagine the consequence of this dilemma in both the work of a multidisciplinary otolaryngological and neurosurgical team that has been recruited to treat a patient with a pituitary adenoma with a transfenoidal approach resulting in a liquor fistula. The decision making side could involve a “tumour board” composed of otolaryngologists, radiotherapists, oncologists, eidologists, histopathologists, nutritionists, phoniatrists, and rehabilitators to achieve the best strategy of contrasting a laryngeal neoplasia that has relapsed. The limits of the team liability model are not restricted to the narrow space of the so-called “uncertain causality”¹⁰, but are even more evident when one examines the content of the performance of each member of a multidisciplinary team.

In fact, it has been wittily observed that by forcing the concept of a guarantee position, especially in the criminal field, for which each health worker is invested with the function of guarantor of the health of the patient, the simple unweighted transposition of a term such as “team” or “multidisciplinary team” from the purely medical field to a meta-legal field has occurred with the sole purpose of extending the horizon of punishability. The team was intended as a form of cooperation between different medical specialties and various other professions but has become a source of a mixed guarantee positions. Precisely, one guarantee position is related to the protection of the patient’s health, which is in fact the content of the health service required of each health care worker, and another extended guarantee position results from the expansion of the concept of “guarantor” towards the other team members’ actions¹¹.

In this way, the rationale of the division of tasks is altered, and the inclination towards mutual trust and respect is eroded, even though it should be the founding element of a team in the pursuit of a positive goal. It would also undermine the personal nature of criminal responsibility. As medical activity is risky in itself, the errors of others could always be considered predictable. Therefore, each team member could be required to monitor and supervise the work of others. Thus, one would risk being charged to answer for the culpable conduct of third parties caused by an unfortunate event, in a *bellum omnium erga omnes*, which indeed is the exact opposite of the concept of teamwork.

Therefore, such an eccentric distortion in applying this concept of team and guarantee position in favour of the patient would always result in an unfavourable outcome being attributed to all professionals who were a part of the treatment. In the criminal field, this introduces a form of joint liability, which could perhaps be digested by the com-

pensatory logic present in the system of civil liability but is certainly alien to modern criminal law anchored in guilt for the fact¹¹.

And in fact, it has already occurred that the otolaryngologist is recognized as responsible for not having correctly intubated a patient, replacing the anaesthesiologist (also considered responsible) or the anaesthetist for not having correctly tracheostomized a patient by replacing the otolaryngologist (to which responsibility has also been attributed). Therefore, it is easy to understand how the scheme of team responsibility offers itself to such distortions and many others that one would hope to be overcome. Certainly, the current application of this scheme with the double profile of protection of the patient’s health and control of everyone’s actions is not well suited in areas of multidisciplinary commitment.

Consider a tumour board where the discussion on the interpretation of eidological and histopathological data and on the direction that a certain meaning attributed to one cause or another could direct the clinical decision. Who would be responsible for an interpretation that later turns out not to be in line with the reality of the case examined? Is it the eidologist, the histopathologist, the otolaryngologist, the radiotherapist, or all of them, and in what proportions? Looking at this team as a modern revision of King Arthur’s liability scheme and the Knights of the Round Table, we can only conclude that the hermeneutics of team liability should be considered as fading and that this is certainly not the area of criminal or civil restorative justice, which should provide an appropriate answer to these questions.

A solution to the dilemma of responsibility: the role of the health care organization as a provider of health care and the legislator’s response in this regard

Due to the intuition of those who work in the world of clinical risk management, a predominant role in the determinism of unfavourable events is attributable to the organizational context in complex systems such as healthcare organizations¹²⁻¹⁴. In fact, it has been estimated that the contribution of human action in the determinism of damage to a person receiving a healthcare service within a structure is equal to 20-30%¹⁵. Even when the damage event can be attributed to the human factor, it must not be seen as an expression of the “monad” of the medical staff, but as a consequence of the treatment process that proved to be defective.

Organizational theories have highlighted how an accusatory approach directed exclusively at the professional is certainly reassuring as if they were holding the “smoking gun” of the error that has just occurred, but this conceals organizational inefficiencies that are hidden behind the verification of an accident. To believe in human error is certainly

a relief, at least because it leads to the certainty that it is an error, which can be controlled and charged (with guiltiness attributed) to a person. However, it prevents us from directly approaching the system to learn about the shortcomings and imperfections that could cause the same adverse events to occur again. The culpability approach has the sole purpose of shifting the responsibility for the performance failure in to an individual or several professionals and in fact might benefit the same flawed structure by deferring its reorganization, which is usually very demanding from an economic point of view ^{16,17}.

It is no coincidence that the so-called health structure responsible for the “organizational shortcomings” was invented some time ago in legal literature ¹². The term was created to emphasize the role of the structure’s organizational activity causing an adverse event but from an equally blameworthy perspective. The aim was splitting up the damage caused by organizational deficit into the causal contribution attributable to the collective action of the structure and the damage attributable to the individual health professional. Thus, this contributes exclusively to shift the focus from the health professional – the last causal link in a complex organizational process – to the institutionally delegated person in charge of the management choices capable of directing and guiding the organization of activities within the structures ¹².

Following this path, the common law systems of the UK/USA ¹⁸ and Italian legislators have developed liability reforms in an attempt to divert the claims of harmed patients from the liability of the professional to the liability of the healthcare facility ¹⁹. In the UK, the system has been in place since 1995 following the institution of the National Health Service Litigation Authority to administer the fund established by the National Health Service to assist Health Service organizations and bodies sharing costs arising from negligence, health care, and professional liability in general. In Italy, after a draft reform was carried out in 2012, it required a new law in 2017, which attempted to overturn the logic of the criminal sphere, proclaiming that events due to errors of any degree are not punishable as long as they occur in the context of activities carried out in compliance with the recommendations contained in codified guidelines or good clinical care practices ²⁰. In the civil sphere, it established a shift of the burden of compensation from health workers to public and private health care companies ¹⁴.

In France, the responsibility of the structure in the occurrence of adverse events related to assistance has been contemplated since the introduction of the law dated 4th March 2002. The advantage of the French system essentially lies in the fact that the victim of an adverse health event is exempted from the burden of proof when the event has occurred during or following risky treatment and when a disabling

condition of certain severity (permanent impairment of more than 24%) has occurred, which grants the victim access to compensation from a special compensation fund. It is a solution borrowed from experiences in New Zealand, where for some time now, not only has the weapon of criminal judgement been inoperative, but a system of no-fault compensation for the damage suffered has also been in place, allowing the patient to quickly obtain adequate remuneration.

The objective of ensuring the safety of care is achieved by balancing the different needs: the protection of the victim, who deserves to be compensated for additional damage suffered, and the protection of the professional, which is the last link in a system that deserves to be reviewed and perfected ¹⁴. In a system set up in this way, the health care professional confidentially reports system dysfunctions worthy of being studied and corrected, and the damaged patient receives rapid compensation for the discomfort or impairment suffered. The structure promotes a constant policy to improve the quality and safety of care, there is no need to hunt for the scapegoat, and everyone cooperates to keep the interest of the patient’s health at the centre of attention. Therefore, it can be well understood how such a system is the best organizational and regulatory response to the dilemma of responsibility in the multidisciplinary approach because it is the most functional tool to maintain the climate of effective collaboration, which is essential to the integration of several professional skills involved to address focal pathologies in their broadest sense.

Information to the patient at the time of “boards”: who is responsible, and what are the repercussions?

For years, the subject of informed consent has been the matter of dedicated conference sessions, and it has been debated whether the correct form of this legal principle should be written or verbal. Among the supporters of the written form are minimalists, who are inclined to minimize communicating information and receiving consent, as well as rigorists, who are inclined towards the preparation of detailed forms. When COVID-19 appeared, the verbal form came back into vogue, but mostly only for precautionary reasons because of the possibility that the virus could remain active on surfaces for several hours/days. It has acted as a stimulus for the development of new ways of recording informed consent (i.e., audio-video recordings) ²¹. Therefore, it is clear that new ways of communication need to be created. And this is even more valid for multidisciplinary contexts, such as boards, where many actors and authors of a diagnostic-therapeutic choice refer to the patient.

First, it is necessary to identify a single clinical reference for the patient – a spokesperson to whom the task of providing information to the patient and collecting consent to the services should be entrusted. This professional figure will act as a hinge that reports the patient's thoughts and questions to the multidisciplinary team and promotes the combined answers. In such a reorganization of the informed consent acquisition process, the dimension of the interview and non-verbal language will be able to recover a thus-far compressed space, and the use of written forms will no longer be the basic instrument for the registration of informed consent. Instead, it will constitute a useful tool to integrate the verbally communicated information.

Since it is addressed to the patient, the tool must be thought usable, easy to read, and easy to understand with drawings and images. Therefore, it will be necessary to initiate the spokesperson's training in verbal and non-verbal communication beforehand so that he or she can positively accomplish such a delicate task. At the same time, it will be necessary to revise the forms used and adapt them to the recipient's needs (the patient). They should be made more functional to receive and understand the information contained that was already displayed during the interview. Finally, it will be essential to promote audit activities within multidisciplinary teams to analyze clinical cases and adverse events that have occurred during care, as well as decision-making processes, the level of patient involvement, and patient satisfaction with the care in a continuous review program that aims to constantly improve the quality of care.

Conclusions

Creating a culture of safety within a multidisciplinary team requires an investment in leadership by each member. This investment is based on one assumption: none of the components can achieve success alone, even within an advanced technological process. The creation of a common governance structure in the organization of an operating team or a tumour board, in which every professional is valued and feels involved in leadership, is fundamental to exploit the commitment and expertise of each of them to ensure patient safety²². This is certainly the best approach to multi-organ pathology governance because involving everyone in a process aimed at quality in best interests of the patient allows the implementation of main positive actions capable of overcoming the *limes* while respecting its content through the integration of skills.

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