REVIEW ARTICLE

Medicolegal Considerations in Multidisciplinary Cancer Care

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ABSTRACT

Health professionals participating in multidisciplinary team (MDT) cancer meetings may not be aware of their medicolegal obligations. This commentary aims to identify medicolegal issues concerning multidisciplinary cancer care and provides recommendations for future implementation. Predominant medicolegal issues related to MDT care were identified in the literature; these include patient consent and privacy at MDT meetings, professional liability, formal expression of dissenting views, and duty of care. Analysis of the literature prioritizes several recommendations for managing these issues. With limited precedent on which to base recommendations, this article identifies the formative evidence that may guide the management of these issues in future MDT practice.

Keywords: Multidisciplinary; Tumor board; Medicolegal; Cancer; Oncology

Introduction

Multidisciplinary team (MDT) care in cancer medicine has become widely recognized as part of best practice management.[1,2] MDT care is recommended by many guidelines and statutory bodies in North America, Europe, and Australia.[2–5] Central to this approach is the MDT meeting or tumor board, in which experts from each field generate a consensus treatment recommendation.[6] MDT care is associated with improved survival, timeliness of treatment, and adherence to guidelines.[7–12] But relatively few clear policies stipulate the essentials of MDT practice. As one example, the European Partnership for Action Against Cancer identified five core areas in cancer care organization: (1) care objectives, (2) organization, (3) clinical assessment, (4) patients' rights, and (5) empowerment and policy support.[2]

The legal requirements of MDT care have not been extensively described or standardized. In a review of the head and neck cancer MDT care, survey data from pharmaceutical company employees in 29 countries identified guidelines for MDT implementation in several countries, but with specific legal information only publicly available in France.[13] The mandatory components of MDT meetings in France include a statement of organization, minutes of each meeting, and at least a twice-monthly schedule.[14] A lack of information about medi-

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colegal implications of MDT decision-making was identified in expert forums in Australia.[15]

Related to the lack of both clinical and legal framework is the clinicians' concern about the medicolegal implications of MDT care, which may act as a barrier to implementation.[1,4,13] Not only are there medicolegal concerns over team-based decisions but also issues about potential conflicts of opinion with other members. An Australian survey study revealed that doctors participating in MDT meetings may lack awareness of their individual accountability for the decisions made in the meeting. This study showed that only 48% of participants were aware of this individual liability.[10,16] These data contradict the very purpose of multidisciplinary care to decrease medicolegal risk—it has been found that MDTs lead to improved documentation, communication, and timeliness of diagnosis and treatment, which are the leading causes of litigation in cancer care.[17]

This commentary aims to identify the key medicolegal issues concerning the MDT approach in cancer and review the recommendations for implementation. The search for this review was conducted on MEDLINE using the Ovid interface and PubMed databases with the following groups of search terms: ("legal issues" OR "legal considerations" OR "medicolegal") AND ("multidisciplinary care" OR "multidisciplinary team" OR "tumor board") AND ("cancer" OR "cancer care" OR "tumour" OR "oncology"). This yielded a total of nine peer-reviewed journal articles. Two of these were included on the basis of their relevance to the aims of the study, whereas the remaining seven articles were excluded owing to lack of content of medicolegal issues. We also hand-searched the reference lists of 21 papers, which yielded additional 17 relevant articles. Predominant medicolegal issues related to MDT care were identified and analysis of the literature provided formative evidence to assist in creating recommendations for future multidisciplinary care. The key issues are highlighted in Figure 1 and recommendations are summarized in Table 1.

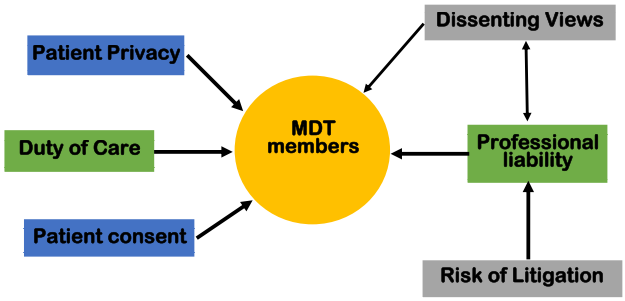

Figure 1. Medicolegal issues surrounding MDT membership. MDT, multidisciplinary team.

Medicolegal Issues

Patient Consent and Privacy

Three publications addressed the issues of managing patient consent and privacy as key issues for MDTs.

A consensus statement from an Australian national forum proposed that patients discussed at MDTs be protected by the same principles governing doctor-patient confidentiality as in individual consultations.[1] Although it was deemed unnecessary to deidentify patients during MDT discussions, the forum proposed that MDT members should have an opportunity to declare a conflict of interest and opt-out of decision-making. It also recommended that patient consent should always be obtained before a referral to the MDT meeting takes place, regardless of whether clinicians will bill the patient for a case discussion. This is the responsibility of the treating clinician, although it may be delegated to another team member. Informed consent requires that the following conditions be met: (1) patients understand the purpose of the MDT meeting, (2) they are aware of the disciplines that may participate, (3) they are informed about those who will be present in an observational capacity, and (4) they are informed about the data from their medical history that will be shared.

An audit of 51 Australian hospital MDTs across a range of tumor streams (breast, gynecologic, lung, prostate, and colorectal) found that one-third of patients were not informed that their case would be discussed by the MDT.[18] Furthermore, patient consent was not sought for half of all cases discussed. Similarly, a 2015 survey of 37 MDTs found that mostly verbal consent was elicited, and it was rarely written in the medical file.[19]

There are two key recommendations in this regard. First, informed consent should be obtained, either in written or verbal form, and documented in the patient's medical record before the case is discussed at an MDT meeting. And second, patients do not need to be deidentified during MDT discussions. However, due diligence should be exercised to ensure that patient confidentiality is maintained outside the meeting setting.

Duty of Care

Six publications addressed the issue of duty of care and whether it was shared by all MDT meeting attendees.

In North America (with a predominantly a common law system), a study indicated that through a formal referral process, the consulted doctor assumes a duty of care for the patient.[20] The court considers the following when determining whether a referral is formal: (1) the existence of a written referral, (2) the extent of the information given to the specialist, (3) the awareness of

Table 1. Key Recommendations for Medicolegal Issues in Multidisciplinary Cancer Care

Domain	Recommendations
Patient consent and privacy	Informed consent (written or verbal) should be obtained from a patient and documented in medical records before their case is discussed at an MDT discussion. Patients do not need to be deidentified during an MDT discussion. However, due diligence should be exercised to ensure that patient confidentiality is maintained outside the meeting setting.
Duty of care	MDT members who contribute to the treatment plan and decision-making process should be identified and their names recorded as they have a duty of care to the patient. The final treatment plan (including patient preference) should be recorded and communicated to the referring practitioner in a timely manner (this may be the general practitioner).
Professional liability	Doctors who contribute to the MDT 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	Dissenting views about a recommended approach to treatment should be recorded in the treatment plan. When appropriate, alternative treatment options should be discussed with the patient.

MDT, multidisciplinary team.

the patient about the referral, (4) whether the advice will generally be relied on, (5) whether the referral and subsequent advice are documented, and (6) whether the specialist is paid for the consultation. If these are fulfilled, then the consulted doctor owes a duty of care to the patient; failure to provide careful advice renders that doctor liable to direct action for negligence brought by the patient.

In Australia (with a common law system), a study suggested that all doctors present at an MDT meeting owe a duty of care to the patients discussed according to the law.[3] This duty of care arises when the treating physician refers the patient to the MDT. Normally, when a patient is formally referred to a doctor, the latter assumes a duty of care for that patient. Most oncology MDT meetings would be regarded as formal referrals that give rise to a duty of care for each individual doctor.

A consensus statement from an Australian national workshop proposed that all doctors participating in MDT meetings should be aware that they owe a duty of care to all patients that are discussed despite having no personal contact with the patient.[1] It was noted that nonparticipating team members who are present in an observational capacity should not share the duty of care responsibility for recommendations made at the MDT meetings. For this purpose, it is recommended that, for each case discussed, the identity of the team members who contributed to the discussion and decision-making process be documented in the medical record.

Beyond the MDT meeting, an international study stated that the referring physician is responsible for discussing the team's treatment recommendation with the patient after a decision.[13] This discussion should clearly state the goals of the treatment, likely outcomes, potential adverse effects, and any other pertinent information that came to light during the MDT meeting.

In France (with a civil law system), if the treating physician deviates from the plan proposed by the MDT, they are required by law to clearly record the justification for this in the patient's file.[14] In Germany (also with a civil law system), although the recommendations of the MDT are not legally binding, physicians are obliged to critically review the recommendations before their implementation.[21] However, the physician must be able to justify a failure to comply with these recommendations on the basis of medical due diligence.

Clearly, documentation of the MDT meeting discussion is important; it provides a constant reminder to each doctor that they are individually responsible for the team decision.[3] The meeting outcome should be clearly documented in the patient's medical record and communicated to the treating physician. Ideally, the treating physician should be present during the discussion as this is the most important factor to ensure adherence to the treatment plan.[22]

Documentation varies between MDT meetings. Some of the variables recorded may include the following: (1) the presence or absence of specialty physicians, (2) presence of the treating physician, (3) the duration of the meeting, (4) patient follow-up, (5) the need for additional imaging, and (6) change of referral diagnosis or treatment.[22] The use of a template was reported in an audit of multidisciplinary breast cancer meetings in the United States, which was found to increase adherence rates to national guidelines.[23] Similarly, a template for reporting MDT members present and treatment recommendations to general practitioners had been pilot-tested in Australian lung cancer MDTs.[24] In addition, an audit of tumor boards in the United Kingdom reported that 97.1% of their discussions were clearly and accurately documented.[25] The authors revealed that a strict review of the electronic record by the secretarial staff and MDT meeting coordinators occurred after the MDT meetings with subsequent communication with those responsible for documenting the decisions within 48 hours of the meeting. The authors also found the introduction of a proforma to improve documentation.

Key recommendations include the following: (1) for each case discussed, members of the MDT meeting who contributed to the treatment plan and decision-making process should be identified and their names recorded, as they have a duty of care to the patient; and (2) the final treatment plan, incorporating any changes because of patient preference, should be recorded in the patient record and communicated with the patient's referring practitioner, who may be a general practitioner in some cases, in a timely way.

Professional Liability

Not all MDT meeting attendees will be involved in the patient's care. This introduces the question who would be liable if a patient suffered harm because of the agreed treatment and brought a negligence case in relation to their care.[1] Traditionally, medical law assigns responsibility to individuals and not to groups. No cases in which negligence proceedings have been brought against an MDT rather than individual clinicians or hospital have been widely reported in any common law country. Four articles addressed the issue of professional liability.

One author[26] suggested that any group decision must be considered to have been made on the basis of individual opinions of the doctors present. Thus, it is deemed that doctors attending the MDT meetings have been personally consulted about the patient and have come to the same decision as a group, even if a doctor did not speak during the meeting.

Another article discussed the fact that an MDT had no official or legal identity to act by itself, and hence attract, liability for any negligence.[3] This raised the question of who would be liable if a patient suffered harm because of an agreed decision.

In Australia, one study found that a quarter of the MDT recommended treatment plans were not noted in the patient records.[18] In France, legal requirements govern MDT practices, and the opinion of the MDT, including the therapeutic plan and the names and qualifications of the participants, must be recorded in the patient's medical record.[14] In Germany, documentation of MDT meetings has the same requirements as for any other consultation work.[21]

Key recommendations from the above include the following: (1) doctors who contribute to a treatment recommendation within an MDT meeting share responsibility for the decisions within their area of expertise and could be liable if a negligence case is brought by a patient; (2) each clinician may be held legally responsible for decisions made within their field.

Dissenting Views

There are some instances in the literature about how dissenting views are expressed within MDT meetings. For example, a study of 461 lung cancer specialists in North America found that there was no consensus on a preferred treatment in either of two clinical situations when they were asked about their personal preference for treatment if they were to develop lung cancer.[27] Similarly, no single medical professional can possess the necessary background to make optimal treatment decisions independently or avoid inevitable unconscious bias toward their own area of expertise.[13]

A survey of 18 MDT meetings in four Australian tertiary hospitals found that doctors in MDT meetings might not completely appreciate their legal responsibilities and potential liabilities generated by their involvement.[10] This study indicated that even though 85% of doctors disagreed with the final MDT meeting decision at some time, 71% did not formally dissent on those occasions.

A French study revealed that disagreements were most often related to the following: (1) the lack of answers from the evidence base for more complex cases leading to multiple potential treatments, (2) different interpretations of technical feasibility among surgeons, and (3) the lack of consideration of the patient's wishes.[28]

Awareness of their legal responsibilities should encourage an effort to fully explore the opinions of all members during MDT meetings and ensure that no individual or specialty dominates the decision-making at the expense of others.[15] If any doctor feels that their opinion was not considered appropriately, or if they disagree with the final decision, they should formally dissent and have this recorded to remove responsibility for that decision.[1] Ideally, each doctor should document their agreement, disagreement, or abstention from each decision made at the meeting. It has been suggested that, when appropriate differences of opinions about treatment occur, it is important that options are communicated to the patient in an unbiased way.

Key recommendations from this issue include the following: (1) dissenting views about a recommended approach to treatment should be recorded in the treatment plan. (2) when appropriate, an alternative treatment option should be discussed with the patient.

Online MDT Meetings

Not all institutions may have the necessary subspecialties and resources to facilitate individual tumor board meetings. To ameliorate this, online

videoconferencing across centers is becoming increasingly common, particularly in the context of the coronavirus disease 2019 pandemic. Several studies indicate the benefits of such online meetings.

A statewide community cancer center videoconferencing network in Delaware, United States resulted in higher compliance with the American Society of Clinical Oncology and National Comprehensive Cancer Center Network guidelines and improved accrual to National Cancer Institute clinical trials.[29]

In the United Kingdom (with a common law system), lung cancer MDT meetings at a district general hospital in Southend incorporated a tertiary cardiothoracic center in London by means of videoconferencing.[30] It was found that annual resection rates increased by 30% after the introduction of telemedicine MDT meetings and the mean time from the patient's first consult in the clinic to surgical procedure was reduced from 69 days to 54 days. A shorter evaluation time before definitive treatment plan with videoconferencing was also reported by Stevenson et al.[31] for lung cancer MDTs in the United States and Chekerov et al.[32] for gynecological cancer in Germany.

An Australian study on videoconferencing of multidisciplinary breast cancer meetings among three public hospitals revealed increased attendance.[33] There were, however, fewer cases discussed overall and the "formal and regimented" approach by means of videoconferencing precluded vigorous case discussions. Nevertheless, clinical practice guidelines for teleoncology have been developed by the Clinical Oncology Society of Australia,[34] which promotes MDT care for patients in rural and remote areas.

The issues of patient confidentiality and privacy remain the primary concern about the widespread implementation of these systems. To maintain privacy, the availability of an adequate, highly secure information infrastructure is the most challenging obstacle. Whereas various unsecure web-based platforms continue to be used, higher standards for consent and privacy are required. Unfortunately, audits of online tumor boards and their compliance with the various medicolegal obligations of MDT meetings are limited. In addition, the legal implications of international tumor boards, in which experts from developed countries participate in other countries, have not yet been clarified.

Takeda et al.[35] created software for a web-based tumor board that connected four hospitals in Japan (with a civil law system). Staff were given access to a high-security communication line and were able to share patient information in real-time. To maintain patient privacy, access to the software was password protected, it was separated from the internet, and patient anonymity was maintained. Such standards should be a minimum for other web-based platforms used; otherwise, patient privacy cannot be guaranteed.

Limitations

The authors acknowledge the limited number of peer-reviewed articles discussing the medicolegal issues that arise in MDT cancer care. As this was not a systematic review, it is possible that we did not locate all studies relevant to the topic. Future work focusing on the experience of MDTs in identifying and managing medicolegal issues is warranted. Specifically, exploring strategies to overcome these issues within a team-based approach is needed, which may then be implemented in daily practice.

Conclusion

Clinicians participating in MDT meetings may not completely understand their medicolegal obligations, which may pose barriers to their full participation in MDT meetings. Predominant medicolegal issues related to MDT care include patient consent and privacy at MDT meetings, professional liability, formal expression of dissenting views, and duty of care. With limited precedent on which to base recommendations around managing these, this review serves to identify formative evidence that may guide management of these issues in future MDT practice.

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