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Review Article

Malpractice litigation in multidisciplinary cancer care: Navigating medico-legal challenges and shared decision making in India

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ABSTRACT

Healthcare professionals participating in multidisciplinary team (MDT) cancer meetings may not have a comprehensive understanding of their medicolegal responsibilities in current times. This article aims to delineate the principal medicolegal issues pertinent to multidisciplinary cancer care and offer recommendations for future implementation. Key concerns highlighted in this literature encompass patient consent and privacy during MDT meetings, professional liability, the formal expression of dissenting views and the duty of care. The analysis of existing literature prioritizes several recommendations for addressing these issues. Given the limited precedent available for formulating recommendations, this article identifies foundational evidence that can inform the practicing clinicians of these concerns in future MDT practices. Navigating decision-making processes in cancer care poses significant challenges for patients.[1] This article seeks to elucidate the significance of shared decision making (SDM) within the Indian clinical context while pin pointing disparities compared to Western practices. Through a systematic search conducted in Medline and Google Scholar from 2000 to 2019, approximately 400 articles were screened, resulting in the selection of 43 relevant articles (5 from India and 38 from Western sources). The literature underscores a scarcity of information on shared decision making in India as compared to Western contexts, potentially leading to adverse physical, psychological and financial consequences reported by patients. According to one study, While Western data demonstrate extensive involvement of both patients and physicians in consensus-building for treatment decisions, such engagement in India is predominantly observed in tertiary care settings, academic institutions or cases with high therapy costs.[2] Cultural beliefs and biases further influence patient engagement, while communication breakdowns correlate strongly with medicolegal malpractice litigations.[3] Future research endeavours are warranted to explore strategies for integrating shared decision making into routine oncology practice in India. Physicians must actively involve patients or their immediate family members in decision-making processes to ensure a patient-centric approach, thereby mitigating the risks of un-informed decision-making or mistrust in the treating physician's expertise. Efforts such as physician and patient education, tool development, policy formulation, widespread implementation and periodic assessments hold promise for advancing the practice of shared decision making.

1. Introduction

Multidisciplinary team (MDT) care in cancer medicine stands as a widely acknowledged best practice, endorsed by numerous guidelines and regulatory bodies across the world.[4] At the core of this approach lies the MDT meeting, often referred to as the tumor board, where experts from different fields collaborate to formulate a consensus treatment plan. This model of care has been linked with improved patient outcomes, including enhanced

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survival rates, timely delivery of treatment and adherence to established clinical guidelines. Despite these recognized benefits, the framework governing essential aspects of MDT practice remains relatively underdeveloped (Figure 1).

Legal requirements pertaining to MDT care lack comprehensive description and standardization. An examination of MDT care in head and neck cancer, which included survey data from pharmaceutical company employees across 29 countries, revealed that while guidelines for MDT implementation exist in various nations, detailed legal information is predominantly accessible only in selective countries.[5] Notably, France mandates specific components for MDT meetings, such as an organizational statement, meeting minutes and a regular schedule, underscoring the variance in regulatory frameworks globally.[5] Concerns among clinicians regarding the medicolegal implications of MDT care, stemming from the absence of clear clinical and legal guidelines, pose potential barriers to effective implementation. These apprehensions encompass issues related to team-based decision-making and the potential for conflicts of opinion among team members.

A survey conducted in Australia highlighted that a significant portion of doctors participating in MDT meetings may lack awareness of their individual accountability for decisions made during these sessions, with only 48% of respondents acknowledging their personal liability.[6] This data presents a contradiction to the fundamental aim of multidisciplinary care, which aims to mitigate medicolegal risks by enhancing documentation, communication and the prompt delivery of diagnosis and treatment—the primary factors contributing to litigation in cancer care.

This commentary endeavours to identify the principal medicolegal concerns associated with the MDT approach in cancer care and provide recommendations for their effective implementation. A comprehensive search conducted on MEDLINE and PubMed databases, utilizing specific search terms related to legal issues and multidisciplinary care in oncology, yielded a collection of peer-reviewed journal articles. These articles, along with additional relevant literature identified through manual searching of reference lists, formed the basis for elucidating key medicolegal issues and outlining actionable recommendations.

2. Shared Decision Making in Cancer Care

Given the life-threatening nature of cancer and its profound emotional toll, patients often find it challenging to navigate treatment decisions. Shared decision making (SDM) emerges as a dynamic practice in healthcare and a pivotal element of healthcare policies, increasingly embraced by physicians, patients and policymakers alike.[7] SDM entails collaborative information sharing and consensus building between physicians and patients to determine the most suitable treatment, culminating in mutual agreement on its execution. The favourable outcomes, ethical foundation and essence of patient-centred care underscore the imperative of integrating SDM into healthcare protocols.

Patients grappling with serious illnesses like cancer possess a substantial stake in the decision-making process, given the potential for treatment toxicity and lifestyle disruptions. Patient-centred care strives to address the needs of cancer patients and their families, empowering them to make informed healthcare choices aligned with their values, preferences and requirements.[8]

Over the past decade, SDM has gained momentum across numerous countries. In the United States, the Patient Protection and Affordable Care Act promotes patient-centred medical home models to bolster the primary healthcare system.[9] The United Kingdom's National Health Service underscores the significance of SDM by facilitating access to patient decision aids and training physicians in collaborative planning.[10] Norway places a premium on its healthcare system with a national health portal and guidelines for a standardized patient pathway.[11] Similarly, Germany's "Patient Rights Act" upholds the principle of informed decisions grounded in a clinician-patient partnership.[12] Governments in the Netherlands, Spain and Italy have also embraced SDM within their healthcare frameworks.[13]

In India, the implementation of SDM presents challenges owing to cultural and behavioural disparities among patients, their families and healthcare providers. This review endeavours to pinpoint gaps between Indian and Western SDM practices and propose measures to bridge these disparities

3. Medicolegal Issues

3.1. Patient consent and privacy

The management of patient consent and privacy stands as a critical concern for Multidisciplinary Teams (MDTs).[14] A consensus statement from an Australian national forum proposed safeguarding patients discussed in MDTs with the same confidentiality standards applied to doctor-patient consultations.[15] While the de-identification of patients during MDT discussions was deemed unnecessary, the statement recommended MDT members disclose any conflicts of interest and retain the option to abstain from decision-making. Moreover, it emphasized the necessity of obtaining patient consent prior to referral to an MDT meeting, irrespective of billing considerations. This responsibility primarily lies with the treating clinician, although it can be delegated to another team member. Informed consent entails ensuring patients comprehend the MDT meeting's purpose, the involved disciplines, individuals in observational roles and the medical history data to be shared.

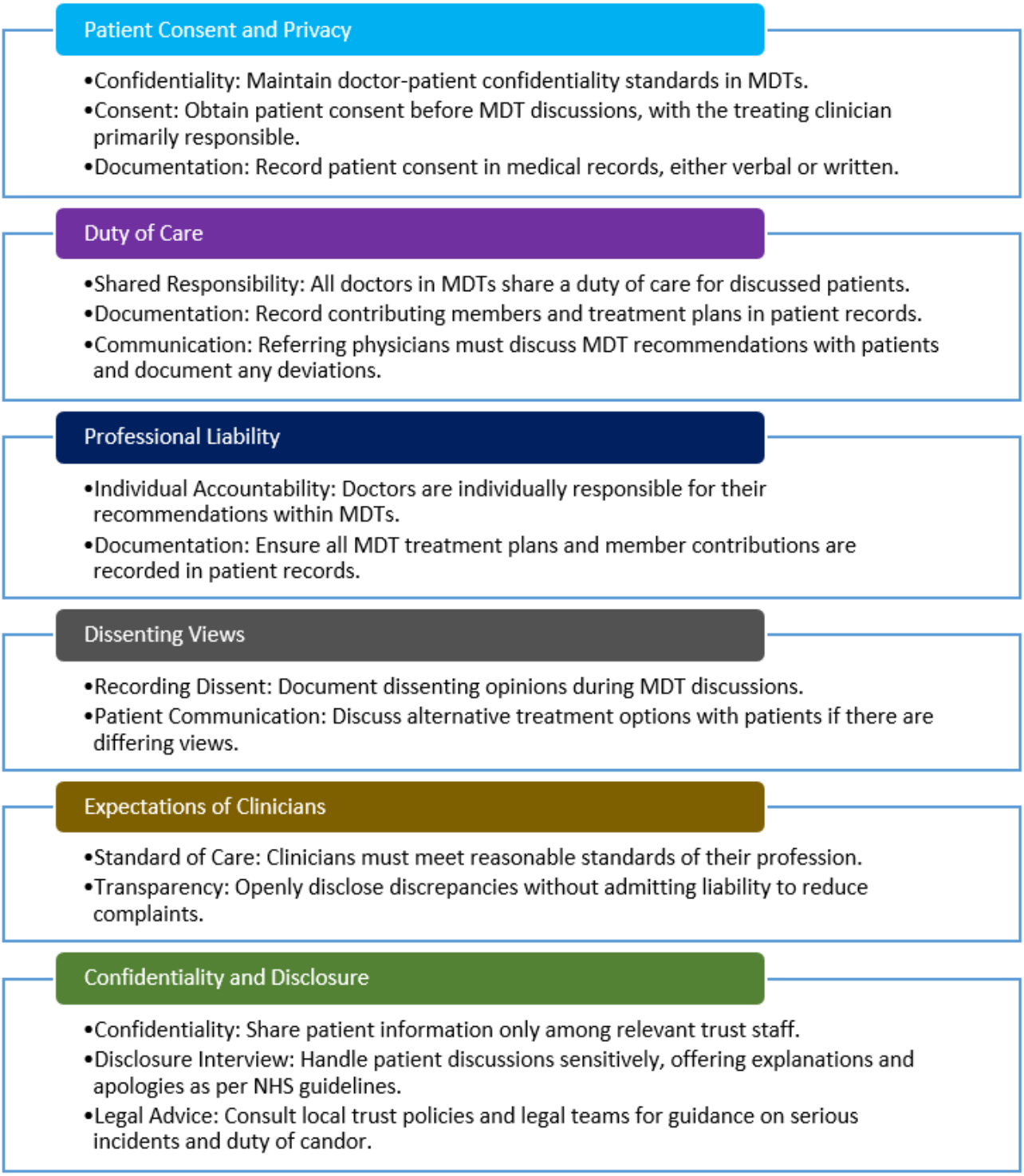

Figure 1: Medicolegal guidelines for multidisciplinary team (MDT) cancer care

An audit of 51 Australian hospital MDTs across various tumor streams (breast, gynaecologic, lung, prostate and colorectal) revealed that one-third of patients were unaware their case would be discussed in the MDT, with consent not sought for half of the cases.[16] Similarly, a 2015 survey of 37 MDTs found predominantly verbal consent obtained, rarely documented in medical records.

Key recommendations encompass obtaining informed consent, whether written or verbal and documenting it in the patient's medical record before MDT case discussions, along with ensuring patient confidentiality extends beyond the meeting setting.

3.2. Duty of care

In a study conducted in North America, it was highlighted that a consulted doctor assumes a duty of care towards the patient through a formal referral process.[17] Several factors are taken into account, including the presence of a written referral, the information conveyed to the specialist, the patient's awareness, reliance on the advice given, documentation and whether the specialist receives compensation for the consultation. Meeting these conditions establishes a duty of care from the consulted doctor to the patient and failure to provide careful advice could render the doctor liable for negligence.

Similarly, research in Australia suggested that all doctors present at Multidisciplinary Team (MDT) meetings owe a duty of care to the patients discussed, originating from the referring physician's decision to involve the patient in the MDT process.[18] This individual duty of care is assumed by each doctor during formal MDT meetings. A consensus statement from a national workshop proposed that all doctors engaged in MDT meetings should recognize their responsibility towards all patients discussed, even if they haven't had direct contact with them.[5] Non-participating members, attending in an observational capacity, are exempt from this responsibility. It is recommended that the identities of contributing team members be documented for each discussed case in the patient's medical record.

Additionally, the referring physician holds the responsibility beyond the MDT meeting to discuss the team's treatment recommendation with the patient, providing clear information regarding treatment goals, potential outcomes, adverse effects and other relevant details. In countries like France, the treating physician is required to document justifications for any deviations from the MDT plan in the patient's file, while in Germany, physicians must critically review MDT recommendations before implementation and provide justifications for any deviations based on medical due diligence.[19]

Documentation of MDT discussions is paramount, serving as a reminder of individual responsibility for team decisions. The outcomes of these meetings should be documented in the patient's medical record and communicated to the referring practitioner. Variables such as the presence of specialty physicians, the treating physician's attendance, meeting duration, patient follow-up, additional imaging needs and changes in referral diagnosis or treatment should be recorded. The utilization of templates has been shown to enhance adherence to national guidelines, as evidenced by audits of multidisciplinary breast cancer meetings in the United States and lung cancer MDTs in Australia. In the United Kingdom, rigorous review and documentation processes have led to improvements in MDT meeting records.

Key recommendations entail the identification and documentation of MDT meeting members contributing to the treatment plan, ensuring the comprehensive recording of the final treatment plan in the patient's medical record and timely communication of this plan to the referring practitioner.

3.3. Professional liability

The issue of professional liability within Multidisciplinary Team (MDT) meetings presents complexity, given that not all participants are directly involved in the patient's care. Traditional medical law assigns responsibility to individuals rather than collective groups. To date, there are no widely documented cases where negligence proceedings have targeted an MDT as a whole, instead of individual clinicians or hospitals.

One viewpoint posits that group decisions in MDT meetings are essentially amalgamations of individual doctors' opinions. This implies that each doctor present has been personally consulted and implicitly agrees with the group's decision, even if they haven't verbally expressed their views. Conversely, another perspective argues that MDTs lack an official legal identity, thus making it challenging to attribute liability for negligence to the group as a whole.

In Australia, a study revealed that a quarter of treatment plans recommended by MDTs were not recorded in patient records. Contrastingly, legal requirements in France mandate the recording of MDT opinions, treatment plans and participant qualifications in patient records. Similarly, in Germany, documentation standards for MDT meetings mirror those of other medical consultations.

Key recommendations emphasize that doctors contributing to treatment recommendations within an MDT share responsibility for decisions within their respective areas of expertise and may be subject to liability in the event of a negligence claim. Consequently, each clinician could be held legally accountable for decisions made within their field of specialization.

3.4. Dissenting views

The literature highlights instances of handling dissenting views within MDT meetings. For example, a study involving 461 lung cancer specialists in North America found a lack of consensus on preferred treatment options in two clinical scenarios, revealing divergent personal preferences if they developed lung cancer themselves. This underscores the impossibility for any single medical professional to possess comprehensive knowledge for optimal treatment decisions, thus avoiding unconscious bias toward their specialty.

A survey of 18 MDT meetings across four Australian tertiary hospitals indicated that many doctors might not fully grasp their legal responsibilities and potential liabilities associated with MDT participation. The study revealed that while 85% of doctors had disagreed with an MDT decision at some point, 71% did not formally express their dissent.

In France, a study identified common sources of disagreement, including the lack of evidence for complex cases leading to multiple treatment options, differing interpretations of technical feasibility among surgeons and insufficient consideration of patient preferences.

Understanding their legal responsibilities should encourage MDT members to thoroughly explore all opinions, ensuring that no single individual or specialty dominates the decision-making process. If a doctor feels their opinion was not adequately considered or disagrees with the final decision, they should formally record their dissent to remove themselves from responsibility for that decision. Ideally, each doctor should document their agreement, disagreement, or abstention from each decision made at the meeting. It is crucial that any differing opinions about treatment are communicated to the patient in an unbiased manner.

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

3.5. Expectations of clinicians

The law expects that healthcare professionals perform to the reasonable standards of their profession. Clinicians may worry that being open and transparent when disclosing discrepancies might be perceived as admitting an error. However, from a medico-legal perspective, this conclusion is not necessarily justified. Patients or relatives who express a desire to complain or seek legal redress should be informed about how to proceed.

3.6. Confidentiality

Patient information is confidential and should typically be shared among trust staff only in relation to managing the patient's treatment.

3.7. Conducting a disclosure interview

To reduce the likelihood of complaints and claims, it is important to understand the likely issues and address them sensitively. When discussing audit findings with patients, the quality and detail of the explanation are crucial. Steps should be taken to manage these conversations carefully to mitigate potential dissatisfaction and legal actions.

Complaints or claims are less likely when patients perceive transparency in the process that led to the interview and receive an apology or expression of sympathy for their current situation. Apologies and explanations, rather than admissions of liability, are encouraged, as outlined in the guidance provided by the NHS Litigation Authority chief executive's letter from May 2009. During the disclosure interview, issues of consent to audit and confidentiality regarding patient data should be addressed.

It's important to note that legal standards are judged according to the year in which the sample was taken, so improvements in screening techniques won't result in retrospective findings of liability. Denials of liability can be as unhelpful as admissions of liability, while a lack of definite advice may lead to allegations of stalling or avoiding the issue. A consistent approach that objectively outlines the issues is necessary. If a legal question arises or access to records is requested, clinicians should refer to local trust policy and consult with the trust's legal team. Providers should demonstrate due diligence in assessing how the duty of candour applies to each serious incident and seek legal advice as needed.

3.8. How to advise patients

Patients should be informed that:

1. Review conditions differ from routine conditions, potentially leading to heightened vigilance and increased reports of abnormalities.
2. Finding discrepancies on review doesn't imply that the same findings would have been made under routine conditions.
3. Hindsight significantly influences image interpretation.
4. - Screening tests operate within established parameters of sensitivity and specificity and may not detect 100% of abnormalities.
5. Interpretation of appearances on scans, slides, or mammograms in screening programs may lead to debates among experts regarding sample classification or image interpretation.
6. Patients have the option to seek a second opinion from another clinician if desired.

Figure 2: Comparison of advantage and disadvantage of shared decision making

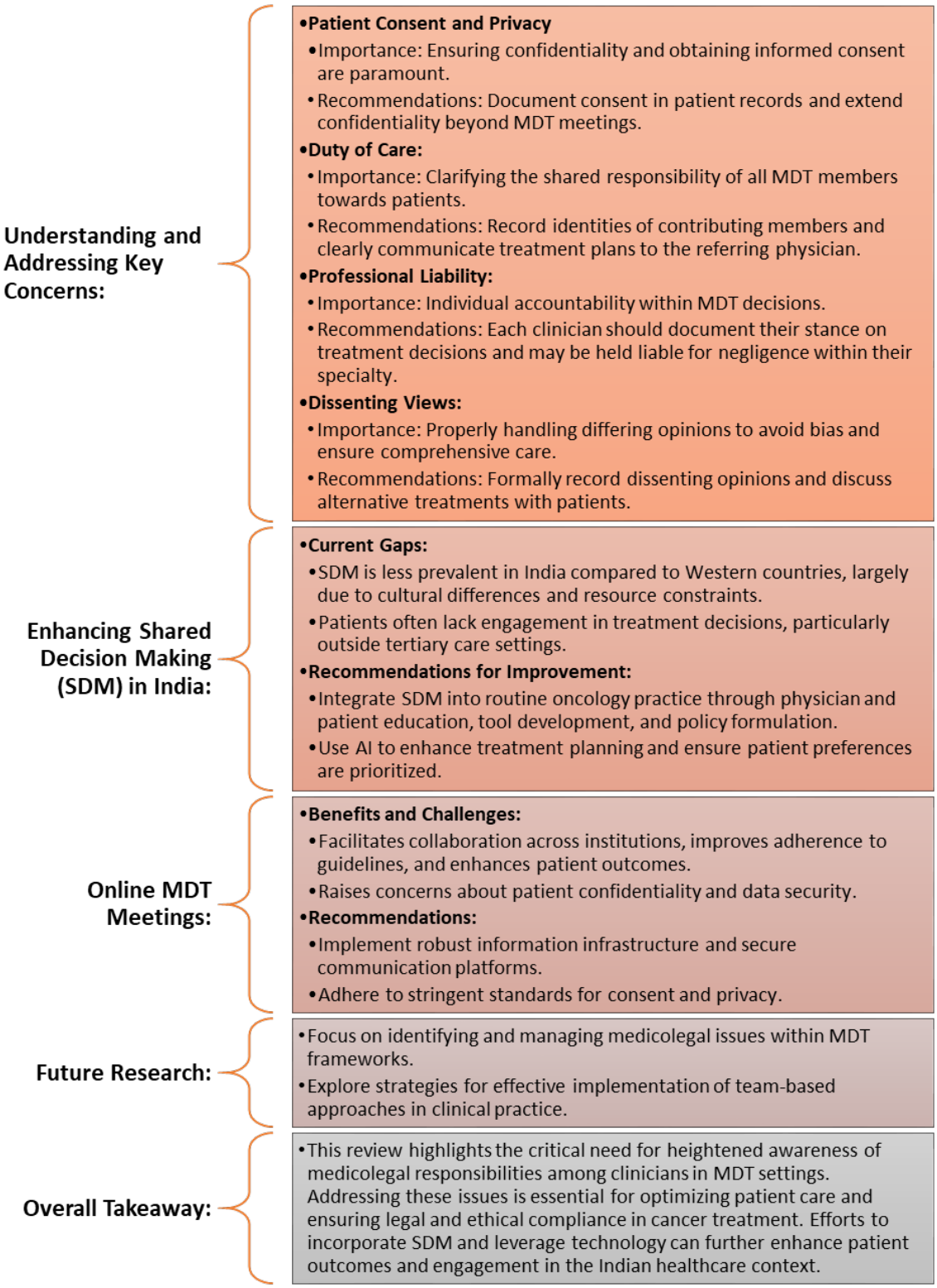

Figure 3: Medicolegal issues in multidisciplinary cancer care and shared decision making in India

4. Burden of Cancer in India and Treatment Options

India reports over one million cancer cases diagnosed annually, with projections indicating a doubling of this burden by 2035. Alongside defining optimal treatment approaches, addressing social determinants like education is crucial. Financial strain is significant for patients and families undergoing cancer treatment, with direct chemotherapy costs being a major contributor. Access to novel therapeutic agents is limited by rising costs, emphasizing the need for patient-centred oncology care and improved educational efforts.

5. Advantages and Disadvantages of Shared Decision Making

Shared decision making (SDM) offers numerous benefits, including customized care, strengthened patient-physician relationships and improved quality of life. Decision-making aids streamline the process and optimize resource use. However, SDM requires extensive training, time and resources. Cultural differences, patient health status and the complexity of treatment decisions pose challenges. Integrating SDM with clinical guidelines remains a work in progress, necessitating ongoing efforts from clinicians and researchers (Figure 2).

6. Medicolegal Aspects

Effective communication and informed consent are vital to mitigate medicolegal risks. Poor communication and lack of information often lead to patient dissatisfaction and increase the likelihood of litigation. Documentation of decision support interventions offers some level of legal protection. While India is evolving towards patient-centered care, SDM has yet to become standard practice. Implementing SDM requires physician training and patient empowerment, considering cultural nuances and resource limitations.

7. Application of Shared Decision Making in India and Bridging the Gaps

India faces a significant gap in SDM implementation compared to the Western world due to poor decision support systems, resource constraints and cultural diversity. A structured approach involving patient inclusion, treatment discussion, preference assessment, consensus-building and decision evaluation is essential to meet unmet needs. Integration of artificial intelligence can enhance treatment planning and efficiency. Policymakers, caregivers and patients must collaborate to bridge these gaps and facilitate SDM adoption (Figure 3).

8. Online MDT Meetings

Not all institutions possess the necessary subspecialties and resources to conduct individual tumor board meetings. To address this limitation, online video conferencing across centres has become increasingly prevalent, especially in light of the COVID-19 pandemic. Several studies have highlighted the benefits of such online meetings.

For instance, a state-wide community cancer centre videoconferencing network in Delaware, United States, led to higher compliance with clinical guidelines and improved participation in clinical trials. In the United Kingdom, telemedicine MDT meetings for lung cancer resulted in increased resection rates and reduced time to definitive treatment. Similar positive outcomes were observed in studies conducted in the United States and Germany for lung and gynaecological cancer, respectively.

Despite these benefits, concerns about patient confidentiality and privacy remain paramount. The widespread implementation of online systems necessitates robust information infrastructure to ensure data security. While various platforms are used, stringent standards for consent and privacy are essential. Moreover, the legal implications of international tumor boards involving experts from different countries have yet to be clarified.

Some initiatives, such as the web-based tumor board software developed in Japan, exemplify efforts to maintain patient privacy through secure communication channels and password-protected access. Such standards should serve as a minimum requirement for all web-based platforms to guarantee patient confidentiality.

9. Limitations

It's important to acknowledge the limitations of this review, including the limited number of peer-reviewed articles discussing medicolegal issues in MDT cancer care. As this was not a systematic review, there's a possibility that some relevant studies were not included. Future research should focus on exploring strategies to identify and manage these medicolegal issues within the framework of team-based MDT approaches, with the aim of implementing effective solutions in clinical practice.

10. Conclusion

In conclusion, this review underscores the need for improved understanding of the medicolegal obligations among clinicians participating in MDT meetings, as inadequate awareness may hinder their full engagement. Predominant medicolegal issues in MDT care include patient consent and privacy, professional liability, expression of dissenting views and duty of care. While there's limited precedent for recommendations on managing these issues, this review provides valuable insights that can inform future MDT practice and guide efforts to address

these challenges effectively.

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None.

12. Conflict of Interest

None.

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