



PO Box 745 Indooroopilly QLD 4068 AUSTRALIA Ph 1300 662 173 or +61 7 3378 2668

Email info@pacificsolutions.com.au Web www.pacifictranscription.com.au

**pacific
solutions**

MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 5 NOVEMBER 2014 AT 6.15 P.M.

THE TOPIC:

MULTIDISCIPLINARY TEAMS

SPEAKERS: DR MARK SIDHOM
MR BILL MADDEN

Transcript prepared by Karen Russell

This transcript is the joint property of Pacific Transcription Solutions and the authorised party responsible for payment and may not be copied or used by any other party without authorisation.

DR MICHAEL DIAMOND: Good evening ladies and gentlemen. It is my pleasure to welcome you all here this evening. We have a very interesting topic. It is something that affects many of us in the work we do, both medically and legally, in that we do work in multidisciplinary teams and we have to share responsibility and decision making. We also have to face consequences and there are sometimes quite convoluted lines of connection between those various entities.

We have two excellent speakers with all the experience you may wish for to talk about this issue. Just by way of introduction, I consulted one of the major information services of our time and I discovered on Google that we have two habitual offenders who appeared in 2007 at a symposium that was run through the Clinical Oncological Society of Australia addressing this very issue - multidisciplinary care, what are the medico-legal implications?

I went through the proceedings and found that it was a very detailed exploration of some case material. Both our speakers were part of a panel, which included a number of people. It would be of interest, if any of you wanted to go back to that, to look at what was current and what was being looked at seven years ago and to see how those issues are now being played out in the current environment.

We have our two speakers and we will first hear from Dr Mark Sidhom, who is both medical and legal. Mark has a Bachelor of Economics and Law prior to graduating from medicine from the University of Sydney. The background that Mark now has is that he specialises in radiation oncology. He completed his training in that field in 2008. His sub-specialty field is in treating genitourinary malignancies and I assume it involves mainly males, because the organs that are listed would be male, and other malignancies such as soft tissue sarcomas.

Mark has interest and experience in national genitourinary cancer co-operative groups and research bodies. His main area of research interest is the management of organ motion in post-prostatectomy radiotherapy and stereotactic body radiotherapy for prostate cancer. You could well imagine that would involve the experience of working in the team environment.

I will introduce our second speaker after Mark has addressed us and we will then finish with questions and a panel to address those questions. Without further ado, Mark, would you continue?

DR MARK SIDHOM: Thank you very much Michael and thank you to the organising committee for asking me to come today.

Out of interest, I would like to know what proportion here tonight are medical professionals and what proportion are legal professionals. I see medical professionals are about 25 per cent, but big in heart I am sure. So thank you all for braving the near cyclonic conditions outside.

Tonight's topic is the medico-legal implications of group decision making in multidisciplinary teams. I will speak from a clinician's perspective and then Bill Madden will address it from a legal perspective.

In my sub-specialty of oncology, multidisciplinary teams (MDT) have become an important decision making forum for patients. These team meetings bring together surgeons, radiation and medical oncologists, physicians, radiologists, pathologists, haematologists and allied health professionals. It brings them all together into a room to discuss patients with a new diagnosis of cancer in order to generate a treatment management plan for them. Also presented or represented to the MDT are patients who have relapsed and need some additional specialist input. With the input of all those doctors in the room, a team management plan is made and acted upon.

There is some limited evidence that decision making in MDTs is beneficial. There is also evidence to say that treatment plans coming out of an MDT are more likely to reflect recommended guidelines than treatments generated by clinicians working in isolation. It is more efficient, with more rapid progress from diagnosis to commencement of treatment and rapid referral patterns inside an MDT.

There is some very limited clinical data suggesting patients managed through an MDT have better cancer outcomes, doing better in the long term than patients who are managed in isolation. There is also some increased recruitment into clinical trials. It is arguable now that in many cancer sub-sites their guidelines state management through the group decision making forum of an MDT, is considered the standard of care. In France, for

example, it has been legislated that virtually every new cancer diagnosis is to be discussed in an MDT.

However, this group decision making forum raises an interesting medico-legal question which is well illustrated by a case that I saw when I was a first year registrar. It was this case that kick started my interest in this area. I will set the scene for you.

It is a very busy head and neck MDT at a tertiary referral centre. The MDT meets every Friday. It is a mega meeting going from 8:00 am to midday. It is always fully booked. The previous week was a public holiday so this particular Friday MDT is overbooked and running late.

The second last patient to be discussed was a 39 year old male bricklayer from Queensland. Twelve months prior to this presentation at the MDT, this young man had presented with a large squamous cell carcinoma of his lip. He had had it excised at a hospital in Queensland. On histopathologic examination there was peri-neural invasion, indicating an aggressive tumour with a high chance of recurrence. Appropriately he then had post-operative radiotherapy to the area from where the cancer had been excised. Unfortunately the dose of radiotherapy of 40 gray and 20 fractions was grossly inadequate. It was of no therapeutic value but did compromise any future treatment to that area. In essence his aggressive tumour had been undertreated. One year later he had re-presented to the hospital with an enlarged submental lymph node, which is in the draining area from the lip. A needle biopsy confirmed recurrent cancer. MRI and PET scan investigations showed no other site of disease. He then underwent a bilateral neck dissection. Twenty four nodes were present in the excised specimen and only one of them contained carcinoma. It was at this point he was referred to the head and neck MDT of which I was part.

The MDT reviewed all material and decided that as he had had a recurrence in the neck, his neck needed to be treated with radiotherapy. With respect to the lip, even though it had been undertreated one year before, as there was no sign of tumour it did not need to be retreated. Moreover to retreat the lip would be very toxic to the tissues because of the prior radiation.

The team was just about to move onto the last patient for the day when the radiologist stopped proceedings. He put up the PET scan, saying there was some very faint uptake

in the left mandible that had not been reported on. He then put up the MRI saying it showed fat replacement in the bone and thickening of the inferior alveolar nerve consistent with a malignant infiltration along that nerve. This is how these cancers spread; along the nerve which is like a highway for these cancers.

After that review the MDT decision was changed. This man now had a recurrence in his mandible. Accordingly he now needed high dose radiation to his mandible as well as to his neck. However whenever the mandible is given a high dose of radiation, all the teeth must be removed. This man now needed a complete mandibular dental clearance. So the head and neck surgeon, the chairperson, left the meeting room with the maxillofacial surgeon to explain all this to the patient. The patient was told he needed to have all of his teeth removed from his lower jaw and then have intensive radiotherapy treatment. The patient was understandably distressed but agreed to go ahead with the recommended treatment.

Two days later the patient went into theatre and underwent the dental clearance. It was the Maxillofacial Fellow, and not the consultant, who did the procedure. When he came to remove the teeth from the left side he looked into one of the sockets and could not see any tumour. He inspected the inferior alveolar nerve and it looked perfectly normal. Accordingly he took some biopsies from the socket and then completed the dental clearance. When the patient woke up, the Fellow asked the patient whether he had had any problems with his teeth on that side. The patient told him that about eight weeks ago he had had a tooth abscess treated with antibiotics for a month. That tooth abscess would also result in PET and MRI findings similar to those seen at the MDT. The biopsies were reported as cancer free. The patient had no tumour in his mandible at all. The following Friday the case was rediscussed in the MDT and it was noted that he had had no tumour in the mandible. An error had been made and this man had had an unnecessary dental clearance. That error was then immediately disclosed to the patient, who of course was very upset.

It was this case 10 years ago in 2004 that raised in my mind at that time, as I sat there in the back of that room, a really important question. Present in that room were four ENT surgeons, two plastic surgeons, a maxillofacial surgeon, four radiation oncologists, a medical oncologist, a pathologist, a radiologist and all of their respective fellows and registrars. So who made

that decision? Who was in error? Who actually made the call and made the mistake?

Was it the maxillofacial surgeon? He/she would say the MDT said the patient was going to have high dose radiation to his mandible. I was consulted to say what needed to be done prophylactically to prepare the jaw for radiotherapy. My opinion was that if the patient was going to do radiotherapy, I needed to remove all the teeth which I did. Was it the radiologist who called the PET and the MRI findings? He/she would say what was said was the PET and MRI findings were consistent with but not diagnostic of malignancy. Was it the treating radiation oncologist who was going to irradiate the mandible? He/she would say I had not even met the patient at this point. The MDT determined there has been a recurrence and in that setting I gave a recommendation as to treatment. Was it the chairperson or all of the doctors? In this group setting where does legal responsibility lie?

Bill Madden will address that question later tonight. What I want to talk about is a survey that I did after that incident. I was interested in two main questions. The first question was what do the doctors who attend the MDT think is the responsibility attached to their participation in an MDT? Do they believe they are free of responsibility as it is an informal chat, or do they believe they are responsible and potentially liable for the decisions made in an MDT? The second question was, are MDTs conducted in a way which reflects the potential legal liability of the MDT doctors? I will explain what I mean by that a little later.

I generated a 35 question survey. I took it to 18 multidisciplinary meetings held at four tertiary referral hospitals in the city that I was in. I had 136 responses being a high response rate of 91 per cent. The main MDT types were Head and Neck, Breast, and Lung making up two thirds of the total number with Gynaecology, and Lymphoma contributing another quarter. Most of the clinicians who filled out the survey were either surgeons (27%), radiation oncologists (32%) or medical oncologists (18%) with some respiratory physicians and haematologists (18%).

The first issue was do doctors believe they are responsible and potentially liable for decisions made in an MDT by being part of that meeting? Half the doctors felt they are not responsible for the decisions that are

made in the MDT. Those doctors felt they would only attract liability if they ultimately became directly involved in the patient's management. When you break down those responses by the different specialties, there was not a big difference between them. Perhaps the surgeons felt they were slightly less responsible than the others but in reality roughly 50 per cent of respondents felt that their participation was free of legal responsibility.

I also broke down the answers according to type of MDT clinic. There are two main MDT clinic types. One is the MDT where the patients attend the hospital on a day before the meeting. The doctors meet them, even if only briefly. However the doctors do see and meet the patients before going to the MDT to discuss them. The other model of the MDT is where the patients do not come to the hospital. Instead a doctor who has seen them provides all the information including the results of all investigations, x-ray films etc and presents this to the MDT. Hence the doctors in the meeting do not meet the patient. I wanted to know whether there was a difference in doctors' perceptions of their responsibility depending on whether they did or did not meet the patient.

I found that in clinics where patients attend and the doctors meet them, roughly 40 per cent of the doctors felt they had no legal responsibility. However in clinics where the doctors do not meet the patient, almost two thirds of the doctors felt they had no responsibility. This is despite the fact it is a scheduled clinic with an agenda. The patient's name and medical record number is detailed. The patient's history and all of their investigations and sometimes their pathology slides are reviewed. The only difference is the doctors sight the patient.

The second part of the survey was to determine whether MDTs are conducted in a way that reflects the potential legal responsibility of the individual MDT participants. For example, if everybody in the meeting is potentially liable, then you would expect a very free and open discussion environment, where every opinion is heard and regarded. Two thirds of doctors felt that that was the case. However a substantial minority, that is one third of the doctors, felt that there was a muted discussion, or a dominant opinion, or generally some relevant issues were not discussed.

Another question I asked the doctors was had they ever had a major disagreement with the MDT decision such as disagreeing with the ultimate treatment modality that was recommended by the MDT. Eighty five per cent of doctors said that at some point, at least once, they had had a major disagreement with the decision. This is to be expected as you would anticipate that in such large groups there should be some disagreement. I then asked the doctors whether in those situations where they formally dissented from the ultimate decision was that dissent noted or minuted. My thinking is that if you strongly disagree with the decision and if you believe you are potentially liable for a wrong decision, then you would have that recorded. However 70 per cent of the doctors said that even when they had a major disagreement with the decision, they did not have their dissent recorded.

To sum up my presentation, I am of the view MDTs in oncology are a very important decision making forum. They are extremely useful for both doctors and patients. I partake of them every week and find them indispensable. However many doctors in that setting believe their involvement is advisory, without any legal responsibility. This is definitely the case to some extent, where the MDTs are not conducted in a way which reflects the potential liability for the clinicians involved.

I will conclude with a happy ending of sorts by telling you what happened to the young man from Queensland. He started his radiotherapy just to the neck and not to the mandible. However within four or five days of treatment he complained of some ulceration on his buccal mucosa, just inside his mouth. This ulceration would be an unusual reaction to radiation so early in its course. Accordingly this thickening and ulceration was biopsied and proved to be tumour recurrence not previously evident. I say a happy ending of sorts because as his teeth had already been removed the radiotherapy fields could be increased to cover that area without any further intervention or delay. He was able to have the appropriate salvage treatment effectively immediately. So in the end nothing came of the erroneous MDT decision.

Thank you very much.