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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

DR MICHAEL DIAMOND: I just want to highlight what a beautifully elegant demonstration it is of the issues and the case is very well and clearly presented. It raises all the issues that I am sure our next speaker will pick up on.

I am certain our next speaker, Bill Madden, is known to all of you here. Bill is a friend of the Society and has presented to us in a different forum at previous annual general meetings and we are very happy to have him join us again this evening.

Bill Madden is the national practice manager in Slater and Gordon, Lawyers. He is an Adjunct Professor at Australian Centre for Health Law Research, School of Law, Queensland University of Technology and an Adjunct Fellow at the School of Law at the University of Western Sydney He has published widely with Janine McIlwraith as the co-author of *Health Care & the Law*, which is in its sixth edition, and of *Australian Medical Liability*.

I am sure that is a very small representation of his knowledge base. As an aside, I saw a blog of Bill's which I flicked through this evening. It is one of those that when you think you are getting to the end of the topics it flicks up halfway again and you just keep seeing more and more and more material. I do not know how Bill does all that, but it is an extensive list of very interesting material, so Bill, thank you.

MR BILL MADDEN:

In preparing this presentation I started off by trying to find out whether there were any case examples we could look at, where there had been essentially a finding of breach of duty for not referring a patient to a multidisciplinary team. I think the answer to that seems to be no, although David Higgs is in the audience this evening. In *Varipatis v Almario* David got fairly close, in that there was identified a couple of options for referral of this particular gentleman either to an obesity clinic or for gastric surgery. I think, David, you will probably agree, it was the referral to the MDT that was probably close to being held to be the standard of care in that procedure. However David is not nodding at me deliberately, so I can just keep going without knowing what his answer is.

I have extracted some quotes from that decision where there have been references to these referrals possibly to multidisciplinary clinics in that case. For example:

"The plaintiff accepted, at least in this Court, that the preferred course for the treatment of obesity was a medical multi-disciplinary approach. The weight of the evidence given by the endocrinologists and hepatologists… was that referral to a surgeon by them would have been possible but unlikely…" and

"The primary judge first identified the 'available modalities of treating morbid obesity' as 'either referral to a multi-disciplinary clinic like the RPA Obesity Centre, or bariatric surgery'" and

"… Dr Jeong's later evidence that that a multi-disciplinary approach to weight loss was the 'best we have'…"

However this issue was not central to the outcome of the litigation. Mr Almario did not call any evidence as to the likely course which would have been taken if he had been referred to the RPAH obesity clinic, but had been unsuccessful in reducing his weight sufficiently.

There was the case of *Le Brun v Joseph & Ors* in Western Australia in 2006 where there was a suggested referral to a multidisciplinary team for arterio-venous malformation (AVM) treatment. His Honour noted:

"According to the uncontested evidence of Dr McAuliffe, which I would accept, in 1999 most patients who were diagnosed with an AVM in Australia were **referred at an early stage to a multi-disciplinary body** of specialists known as the AVM Board … " and

"… it was not essential for a newly diagnosed patient to be referred to an AVM Board before embarking upon treatment, but this was usual in the case of publicly funded patients such as the plaintiff. **I find that the plaintiff would have been referred to the AVM Board** in Perth."

However again this was not central to the outcome.

On that point I could probably end my talk. However what I have come up with to talk about this evening, are five questions which we might address about these settings to see what the issues might be. The five questions are:

1. Was the patient told of the planned MDT and, if not, might the **disclosure of information** by the treating clinician give rise to liability for breach of confidence or under privacy legislation.

2. What obligations may fall upon team members for **keeping of patient records**? Can there be access to such records by the patient on request/**subpoena**.

3. If the MDT produced varying or dissenting opinions, not conveyed to a patient, might that omission form part of a "**failure to warn**" claim.

4. What if the **MDT decision is wrong**; and

5. What is the position regarding **corporate liability**: vicarious liability, non-delegable duty or direct liability for public hospitals, private hospitals and other clinics.

Firstly: **was the patient told about the multidisciplinary team meeting** and, if not, might the disclosure of information by the treating clinician give rise to liability for breach of confidence or under privacy legislation?

There has been an article published in the Asia-Pacific Journal of Clinical Oncology 2011; 7:34-40 by Wilcoxin and others titled *Multidisciplinary cancer care in Australia: A national audit highlights gaps in care and medico-legal risk for clinicians surveyed in 155 hospitals*. They found that for those patients that had MDTs, **one third of the patients were not informed that their case would be discussed**. This may not matter but under the law a doctor is under a duty not to voluntarily disclose, without the consent of their patient, information the doctor has gained in their professional capacity save in very exceptional circumstances: ***Hunter v Mann*** [1974] QB 767 at 772.

However a more complicated issue is the privacy legislation. An example of such a case about disclosure was that of ***KJ v Wentworth Area Health Service*** in 2004. In this case involving the Nepean Cancer Centre a particular lady's (KJ) psychology and psychiatry records were, as part of this team environment, put in with her general medical records. She became aware that this had happened and made a complaint on the grounds it was neither necessary nor appropriate. KJ was successful in

her assertion that that the Area Health Service breached Information Privacy Principle 3 (as it then was). It has been changed a little since then, but nevertheless, it was a breach at the time. KJ described this problem in her submissions as a systematic problem where there was a gap between the failure to align **the expectations of patients** and the **culture of disclosure** that exists in the medical profession where everyone talks about their patients with each other. Lawyers do the same, and it is of interest that the Tribunal did not quite have the same view. As the *Health Records and Information Privacy Act* 2002 (NSW) was to be implemented in 2004 the Tribunal chose not to refer the matter to the Minister and the Privacy Commissioner.

The question which we are left with under this first heading is: if the Wilcoxin study suggests that we have a third of patients not even being told that their matters are going to be discussed in this broader environment, what is the risk that some of them might later say "I did not give my permission". They would say some of their material was private and inappropriately shared. Therefore they may have an entitlement either for breach of confidence or under the privacy legislation.

I have noticed that part of the open disclosure policy now published by the New South Wales Ministry for Health envisages the use of a **multidisciplinary team in the open disclosure of medical error.** It describes:

"A multidisciplinary team of senior clinicians and … executive representatives specifically put together to conduct, support and oversee the formal open disclosure process for an individual patient safety incident."

This MDT would meet and discuss what has gone wrong with the patient's management. They would then meet with and discuss that process with the patient. It occurred to me, that on one view of it, that might just compound the problem. If something has gone wrong and you are then introducing another group of practitioners to share the information about that patient there could, on occasion, be an undesired outcome from that.

Secondly: **What obligations may fall upon the team members for keeping of patient records**? We know the Medical Board of Australia *Code of Conduct* requires accurate, up to date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other

management. [8.4.1] We also know from the Wilcoxin 2011 article that: **One quarter of patients' medical records did not note the MDT recommended treatment plan.**

I am involved in a matter at the moment where this issue is tangentially relevant. I have seen a set of multidisciplinary team documents and 'sparse' would be a kind word to describe them. It is sort of a chart. It consists of two pages which is probably better than one. It is like a spreadsheet with patient's name, the treating doctors and two line entries. That is about all there is. I wonder whether or not those records are being kept adequately by "the team" - whatever "the team" happens to be. Is there potentially a problem in terms of individuals within "the team" who might, in a way, just abdicate or delegate that role to some central person who is meant to write the records? For example someone just sitting there without paying much attention to what the records actually say and whether those records comply with their obligations under the Code of Conduct or under the expectations of the law about adequate medical records.

I found a disciplinary matter from last week, 29 October 2014, which included complaints about medical records. In this matter of *Health Care Complaints Commission v Street* [2014] NSWCATOD 124 the records were found to be inadequate for failing to record:

- The diagnosis of the practitioner
- Particulars of any **clinical opinion** reached
- Particulars of **advice/information given** to the patient

Perhaps in the example Dr Sidhom gave, there might have been quite a number of people in the room who could not point to a document which recorded any of those things about their input into that meeting. That might make it a bit difficult for medical defence organisations when the time comes for them to try to create a defence for one of those team members whose answer to the question, "can I have a look at your records?" is "that will not take very long, because there none."
Finally can the MDT records be obtained on subpoena for an individual team member? I believe the answer is simply yes and I have done it.

Thirdly: **If the MDT produced varying or dissenting opinions, not conveyed to a patient, might that omission form part of a "failure to warn" claim.** This takes us

back to the issue that Dr Sidhom raised about the possibility that there might be dissenting opinions and whether those dissenting opinions ought be conveyed to the patient as part of a "failure to warn" discussion about material risks. Quoting from Dr Sidhom's own paper (Sidhom and Poulsen, *Group decisions in oncology: Doctors' perceptions of legal responsibilities arising from multidisciplinary meetings*, Journal of Medical Imaging and Radiation Oncology (2008) 52, 287-292), even though **85% of doctors have disagreed** with the final MDM decision in an important way at some time, **71% did not formally dissent on those occasions**. Given the numbers of doctors who do not record their dissenting opinion, that makes it difficult to have them conveyed to the patient.

There are cases such as *Richards v Rahilly* [2005] NSWSC, where the courts have said:

> "It would impose an impossible burden on the medical profession if a doctor was bound to offer a patient every 'legitimate' treatment option that 'could work' and discuss the advantages and disadvantages of each option with the patient and then allow the patient to choose his or her option."

But there are other cases such as *Zaltron v Raptis* [2001] SASC where the courts have said the existence of an alternate diagnosis is a matter that should have been considered in determining the content of the advice to be given to the patient.

Even if there is no dissent, where the multidisciplinary meeting delivers a unanimous opinion, there are still the obligations of conveying that advice to the patient and conveying the material risks. Whose problem is that? Is it the lead clinician? It would seem so. In the *South Eastern Sydney Area Health Service v King* [2006] NSWCA it was noted that regular weekly meetings of the hospital's paediatric oncology group discussed the respondent's case. The court decided:

> "There was no dispute in this appeal that **Professor O'Gorman Hughes had a duty to warn** the respondent's parents of the risk of paraplegia or quadriplegia in the treatment … The judge's finding that he did not perform that duty has not been challenged…"

But can the MDT members assume the lead clinician knows the material risks? What if he does not know? What if it is a radiological risk with which he is not familiar?

Who is then potentially liable? Is it the lead clinician for not finding out or the radiologist for not making him aware of it? In my view if the lack of detail in these records, focusing on what ultimately will have to be advice to a patient is not addressed, then these sorts of issues may give rise to a problem.

Fourthly: **What if the MDT decision is wrong**? If the decision is wrong, there is no legal principle which would avoid liability on the part of an individual member, save perhaps some statutory provisions regarding employees which see their legal liability fall upon their employer. When the decision is wrong somebody like me gets involved and it goes from there as expected. My answer to Dr Sidhom's question about who is sued, is I have no great appetite to sue every single person in the room. You cannot fit all their names on the back sheet of a statement of claim. It is very tiresome and in practice you focus on the people who appear to be fundamentally responsible.

It is not rocket science that in the public hospital setting, in between vicarious liability and non-delegable duty, it may not be necessary to sue anyone other than the lead clinician and the hospital, which picks up everyone else. This was the case in the already cited matter of *South Eastern Area Health Service & Ors v King* in which the 13 year old plaintiff was treated for cancer by way of radiotherapy, systemic chemotherapy and intrathecal chemotherapy. **Only the hospital and lead clinician were sued.**

I must tell you, as counsel recently pointed out to me, that if we do not sue an entire multidisciplinary team we can pretend that the problem of trying to obtain a multidisciplinary expert report can be avoided. This is frightening in itself but the concept of having a multidisciplinary expert conclave of two MDTs agreeing with each other is probably more than we could cope with at this time of night.

Fifthly: **What is the position regarding corporate liability: vicarious liability, non-delegable duty or direct liability for public hospitals, private hospitals and other clinics?** I wanted to raise this, not in the public hospital setting where there is little argument as seen in SEAHS v King, but in the private setting. I noticed as I was doing some research for this presentation that the Sydney Adventist Hospital at Wahroonga has the following on its website at the moment:

> "Expected to open later this year, the San Integrated Cancer Centre is estimated to cost $20 million and is part of Sydney Adventist Hospital's major redevelopment project and planned 25,000 m^2 expansions of existing buildings. The Centre will have a cutting edge and holistic approach to treatment of all major disease types through a single point of patient entry to one warm, caring and peaceful diagnostic, treatment and support precinct. This major new development will be purpose built to provide the gold-standard in cancer diagnosis, treatment, management and care through **a world-recognised, coordinated and supportive multidisciplinary care model**".

This sounds like a fantastic development of course. However if we approach Sydney Adventist Hospital as a private hospital, we find some private hospitals more than others say: 'non-delegable duty has little to do with us because it is the doctors doing their thing and we do not really get involved'. But if these private hospitals are starting to enter the field, by setting up these committees, and in some way providing a mechanism by which they might take place, even if it is just providing a facility or secretarial support then it would seem that would bring them into having some liability for the outcomes of some of those group decisions. Potentially at least that is something that might need to be looked at.

There was a decision with which some of you in the audience will be familiar, in *Idameneo(No 123)Pty Ltd v Dr Colin Gross* [2012] NSWCA where Hoeben JA made a particular point of saying:

> "… in a more traditional medical practice the doctor, as well as providing medical services, would have control over his or her medical records and it would be the doctor's responsibility to keep those records up to date. At the BJMC … it was the **appellant which assumed responsibility** for maintaining patient records. … **I see no difficulty in imposing a duty** to maintain up to date records **on the entity** responsible in the practice for patient records …"

It is along that sort of line of legal territory which I suppose an argument might run.

To conclude, I will refer back to the recently published Wilcoxin 2011 article. There are three key points from that study:

- One third of the patients were not informed their case would be discussed by the team.

- One quarter of patients' medical records did not note the MDT recommended treatment plan. It may have been on some other document somewhere, but it was not in the patient records and that creates a risk.

- Less than 1% reported routine attendance by the tumour-specific minimum core team. This suggests that the actual structural integrity of these meetings was not as rigorous as it could have been.

Arguably, looking at it from the outside, although it seems clear these meetings are a good thing and the quality of the output, one would assume, would have to be better, it is in some ways a somewhat casual approach, particularly on the record keeping area. Wearing my lawyer's hat, that apparent casualness could give rise to reasonably foreseeable and not insignificant risk, about which something could be done without an enormous amount of difficulty. I do not know whether that casualness would change tomorrow if there was some robust litigation focusing on one of those meetings and involving a substantial negligence claim. Perhaps that could and should happen and then might see an improvement in the rigour in which the meetings are run and recorded.

Thank you.