Multidisciplinary specialist treatment teams and abandonment of patients – who is responsible for what?

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The legal and ethical position of treating specialists whose contractual relationship with a patient has been prematurely terminated by the patient or themselves is discussed. The validity of a mandated parent terminating the treatment of a mentally and legally competent patient by a surgeon member of a specialist team is considered. After a contractual relationship between a treating specialist and a patient has been prematurely terminated, the specialist concerned still owes a duty of care toward the patient under the law of delict – until a new specialist in the field has been properly briefed by the previous treating specialist to take over the treatment of the patient. Such previous treating specialists may not rely on other specialists in the multidisciplinary treatment team, who are not specialists in the field, to take over the treatment of the patient, or to brief the new specialist on the patient's condition. In such circumstances, the original treating specialist may be held liable for abandoning the patient. As a general rule, members of a multidisciplinary team may not treat patients outside their specialty – except in emergency situations. In the latter case, however, they cannot rely on emergency as a partial defence, when they themselves have created the emergency. Such members of the team may be cited as joint wrongdoers, if without good cause their conduct contributes to the harm caused by the original treating specialist, after the latter has left the team and abandoned the patient by not ensuring that another specialist in the field has been briefed to take over the patient.

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Consider the following hypothetical situation:

A 20-year-old female is involved in a motor car accident. She is brought into casualty and is seen by the doctor on duty, who assesses her to have abdominal pain, chest pain and facial and pelvic injuries. A scan confirms the facial and pelvic fractures, but the abdomen is clear. The patient is taken to the high care ward and managed by a plastic surgeon for her facial injuries, an orthopaedic surgeon for her pelvic injuries, and a general surgeon for the injuries to her abdomen. The patient remains stable, but states that all decisions about her treatment are to be discussed and decided by her parents, especially her father. The patient is operated on by the plastic and orthopaedic surgeons and transferred to the ward. The patient's abdomen remains soft throughout, but she continues to complain about abdominal pain.

The patient continues to be monitored by the three specialists. The abdominal pain is attributed to the pelvic and chest injuries. After a while, the general surgeon notices that the patient's stomach is becoming bloated. As the general surgeon is about to treat the patient, he is informed by the patient's parents that they are unhappy about the care given by him, and tell him that his services are no longer required. The parents also tell him that they do not want him to find another general surgeon, as they have instructed the orthopaedic surgeon to find another for them. Later, while they are doing their ward rounds for other patients, the dismissed surgeon informs the orthopaedic surgeon about the patient's bloated stomach.

Later during the night, the nursing staff contact the original surgeon and tell him that the patient is unwell. The surgeon tells the nurses that he is no longer treating the patient, and asks them to contact the orthopaedic surgeon. The orthopaedic surgeon visits the patient and puts some treatment in place. The next day the orthopaedic surgeon examines the patient, goes to a conference and hands over his patients to a locum. The patient's condition continues to deteriorate. The orthopaedic surgeon is again contacted and told about the continuing deterioration of the patient, and contacts another general surgeon. The patient dies from a missed perforated bowel injury and septic shock. The original surgeon is charged with misconduct and failing to hand over the patient properly. He says that he thought that the orthopaedic surgeon would immediately contact another general surgeon, and inform the latter about the patient's bloated condition – especially as he had alerted the orthopaedic surgeon about this when they were doing their ward rounds.

The following questions are posed: (*i*) Does a proxy work with a legally and mentally competent adult child, or is it still the responsibility of the practitioner to speak to the adult child? (*ii*) Did the surgeon's responsibility legally and ethically end once the parents dismissed him? (*iii*) Can it be viewed as abandonment if the patient is being managed by a multidisciplinary team? (*iv*) Did the failure to identify the missed perforated bowel injury and septic shock amount to negligence by the original general surgeon?

Does the proxy work with a legally and mentally competent adult child, or is it still the doctor's responsibility to speak to the adult child?

A proxy may be given by anyone who is mentally and legally able to consent to treatment or a surgical operation. It may, for instance, take the form of a written directive made in terms of the National Health

Act No. 61 of 2003[1] prior to the patient becoming incapable of making decisions after a medical procedure (s7(1)(a)(i)). Or it may be made by a patient who is legally and mentally capable of giving informed consent, who for religious, cultural or other reasons wishes their parent or parents to give consent to any treatment or procedure recommended. Patients are entitled to make their consent to treatment subject to certain conditions. Thus adult children may authorise their parents to act as a 'proxies' – even though they are physically and mentally capable of giving informed consent by themselves. Here the parents are not really acting as proxies in terms of the National Health Act,[1] because the Act only refers to situations where the patient is 'unable to give an informed consent' (s7(1)(a)). Otherwise, the practitioner must always obtain the consent of the patient (s7(1)). In such instances, it is advisable for the practitioner to check with the patient in private – in the company of a chaperone if necessary – to ensure that it is indeed the wish of the patient, and that the patient's wishes have not been suborned to those of their parent or parents. Thereafter, the practitioner should record in their notes that this is the wish of the patient, and get the patient to sign it. Good note-keeping is essential for patient follow-up treatment, and can also be used by practitioners should they face any legal challenges.[2] The practitioner should ensure that in the case of an adult patient, (s)he also consents to the treatment or procedure – in addition to any consent given by the parent or parents – as implied in the National Health Act[1] (s7(1)).

The National Health Act[1] also provides that even when somebody else gives a proxy consent, because the patient is legally incapable of giving such a consent – provided the patient can understand – the practitioner must still explain to the patient what the treatment or procedure will involve (s8(1)(b)). Therefore, whether or not the patient is giving consent or capable of giving legal consent, the practitioner must always speak to the patient about the treatment or procedure – even if (s)he is a minor.

The scenario

In the above scenario, the patient is entitled to make it a condition of her giving consent to any treatment or procedure that her parents also consent to it. The general surgeon should have checked with the patient independently – with a chaperone if necessary – to ensure that this was the wish of the patient. At all times the surgeon should have kept the patient and her parents fully informed of the treatment options available, and have allowed them to choose which option they favoured – as required by the National Health Act[1] (s6(1)). It would then be up to the patient to say that she deferred to what her parents decided, and for this to be recorded in the practitioner's notes.

Did the general surgeon's responsibility legally and ethically end once the parents dismissed him?

As the legal relationship between a doctor and patient is contractual,[3] mentally and legally competent patients always retain the right to terminate the services of practitioners who are treating them. This may be done at any stage during the practitioner-patient relationship. Where such termination has been ordered by the 'proxy' of a mentally and legally competent patient who is physically able to give informed consent, the practitioner should check with the patient privately to ensure that this is also the patient's wish – in the company of a chaperone if necessary. The patient's wishes should then be recorded in the practitioner's notes, and signed by the patient.

If the termination occurs prematurely, before the patient has been cured or the treatment regimen has ended, the practitioner needs to ensure that the patient is referred to another practitioner in the relevant field. Such a referral should include providing the new practitioner with a report on the patient's condition, history, treatment regimen and recommended further treatment. If this is not done, the practitioner will be in breach of their legal and ethical obligations, and may be accused of abandoning the patient.[4]

Abandonment of a patient occurs when a practitioner or a patient prematurely terminates the patient's contractual relationship with the practitioner, and the practitioner does not ensure that another practitioner in their field has been properly briefed to take over the patient.[4] This is because while the doctor-patient contractual relationship is terminated, the original practitioner's duty of care towards the patient, arising from the law of delict,[5] remains until a new practitioner has been fully briefed to take over the patient. The law of delict imposes a duty on people generally not to harm others, and is imposed by mere operation of the law, without the parties concerned having to enter into a contractual relationship.[6]

Ethically it is wrong for a practitioner not to act in the best interests of the patient, and to harm the patient by not ensuring that proper follow-up treatment is in place when services have been terminated. Such conduct violates the biomedical principles of beneficence and non-maleficence.[7]

The scenario

In the above scenario, provided that the original surgeon was satisfied that the patient agreed with her parents' wish to terminate his services, and provided that the surgeon gave proper follow-up instructions to whoever was taking over from him, he will have acted legally and ethically. It appears, however, that the original surgeon only mentioned the patient's bloated condition to the orthopaedic surgeon, who is not an expert in abdominal injuries. He did not check that the orthopaedic surgeon had appointed another general surgeon, so that he could hand over the relevant information to the latter. Instead, he seems to have relied entirely on the orthopaedic surgeon to convey information about the patient's condition and history to whoever he assumed the orthopaedic surgeon had approached to take over the patient.

It is clear that the original surgeon did not take steps to ensure that the patient had been handed over to somebody else to provide the necessary follow-up care. When the nurses called him at night and mentioned the deteriorating condition of the patient, the original surgeon should not have simply referred them to the orthopaedic surgeon. He should have called the orthopaedic surgeon himself, to find out who the new surgeon was, so that he could brief the person about his treatment of the patient up until his services were terminated, and his subsequent findings in respect of the patient. The original surgeon's failure to do so was a breach of his legal duty of care towards the patient,[5] which continued after their contract was terminated, as well as a breach of his ethical duty to act in the best interests of, and not to harm, his patient.[7] His conduct therefore could be construed as abandoning the patient.[4]

Can it be viewed as abandonment if the patient is being managed by a multidisciplinary team?

Where a multidisciplinary team is managing a patient, each member of the team is responsible for his or her specialist treatment.[8] Except during emergencies,[8] an individual specialist cannot rely on his or her non-specialist colleagues to take over the patient's management when it is outside their field of expertise. However, in law, a person may not rely on emergency as a partial defence if (s)he has created the emergency.[9] Furthermore, when the services of a specialist member of the team have been terminated, the latter must ensure that another specialist in their field is appointed, and has been properly briefed by him or her on the patient's history and treatment. A failure to do so would be a breach of the specialist's duty of care toward the patient, and would constitute abandonment of the patient.[4] This is because the duty of care continues after the termination of the contractual relationship with the patient, until the treating specialist has handed over the relevant information to the specialist who has taken over the treatment of the patient.

A specialist in a multidisciplinary treatment team may not delegate their duty of care toward a patient who has contractually terminated their services to another member of the multidisciplinary team who is not a specialist in the field of the original treating specialist. This is because in law a practitioner should not undertake work for which (s)he is not properly trained[10] – except in emergencies.[8] If another member of the multidisciplinary team has been asked by a patient or their proxy to appoint a new specialist to take over from the original treating specialist, the latter is still under a duty to ensure that such an appointment has in fact been made, so that (s)he can brief the new specialist accordingly. The duty of care does not end when another member of the team has been delegated to appoint the new specialist. It only ends once the new specialist has been properly briefed by the original treating specialist. As previously mentioned, such a failure to brief the new specialist accordingly may amount to abandoning a patient.[4]

Under the Apportionment of Damages Act No. 34 of 1956,[11] if there is more than one wrongdoer, each wrongdoer may be jointly and severally liable to a person or his or her dependants who have been harmed by the negligent acts or omissions of the persons responsible (s2).

The scenario

In the above scenario, the attempt by the orthopaedic surgeon to treat the patient for the abdominal condition without contacting a general surgeon with the necessary expertise was a negligent act by the orthopaedic surgeon.[10] As previously mentioned, where a multidisciplinary team is managing a patient, members of the team should not take over the functions of other specialists – except in emergency situations.[8] In this situation it appears that the orthopaedic surgeon had himself created the emergency by not earlier approaching another general surgeon to take over the patient of the original general surgeon. While the original general surgeon may be liable for abandoning his patient, the orthopaedic surgeon may be liable for negligently trying to provide treatment in a field in which he was not a specialist – because of an emergency that he himself had created.[9]

In this instance, it appears that the original general surgeon was negligent for not ensuring that the new treating surgeon was properly briefed on the patient's condition, and the orthopaedic surgeon was negligent in not timeously appointing a new general surgeon and trying to treat the patient when he did not have the necessary expertise. Therefore, under the Apportionment of Damages Act,[11] the original general surgeon and the orthopaedic surgeon may be held jointly and severally liable for any harm suffered by the dependants of the deceased patient (s2).

Did the failure to identify the missed bowel injury and septic shock amount to negligence by the original general surgeon?

As a general rule, a medical practitioner is expected to exercise the degree of skill and care of a reasonably competent practitioner in their discipline.[5] In the case of specialists a higher degree of skill and care is expected than that expected of general practitioners.[12] The test is whether a reasonable practitioner in the position of the practitioner concerned ought to have foreseen the likelihood of the patient suffering harm, and have taken steps to guard against it. The test is not whether such a practitioner ought to have foreseen the exact nature and extent of the harm, but whether (s)he ought to have foreseen the general nature of the harm that resulted.[13] However, there is no liability for a mere error of diagnosis if a reasonably competent doctor would have made a similar error.[14] Likewise, there is no liability where a highly unusual, unexpected complication occurs in the treatment of a patient[15] – unless it could be tested for, in which case it would be foreseeable.

The scenario

In the scenario, the test will be whether a reasonable surgeon, in the position of the original general surgeon, would have foreseen the likelihood of the patient suffering harm from a bowel injury as a result of the accident and other injuries that she had suffered, and would have taken reasonable steps to investigate whether or not such an injury had occurred.[12] The test is not whether a reasonable surgeon ought to have foreseen the exact nature and extent of the injury[13] (in this case, a perforated bowel), but whether such a surgeon ought to have foreseen that the patient may have suffered a bowel injury.[12] The fact that the perforation of the bowel was delayed may have influenced the original treatment of the patient, and there would be no liability for failing to detect this if a reasonably competent general surgeon would not have diagnosed it.[15] However, once the bloating occurred, it is clear that a reasonably competent surgeon, whose contractual services had been prematurely terminated, would have complied with their duty of care toward the patient by ensuring that it was followed up by another specialist in their field.

Similarly, in the case of the orthopaedic surgeon, once he had been informed of the bloating of the patient's stomach, he ought to have immediately contacted another general surgeon and not have tried to manage the patient on his own. He not only failed to carry out the request of the patient's parents timeously, but also appears to have put the patient's health at risk. It could be argued that a reasonably competent orthopaedic surgeon dealing with a patient who has suffered pelvic injuries would foresee that as a result of the trauma caused by a motor accident, a patient may suffer from a bowel injury, and that symptoms of this would include continuous abdominal pain and bloating.

Conclusion

Practitioners need to remember that even if their contractual relationship with a patient has been prematurely terminated by the patient or themselves, a duty of care towards the patient continues under the law of delict,[6] until a new practitioner who has been properly briefed by them takes over the treatment of the patient. They may not rely on other practitioners in the multidisciplinary treatment team to brief the new practitioner. Members of a multidisciplinary team may only treat patients outside their specialty in emergency situations – and cannot rely on the emergency as a partial defence when they themselves have created the emergency.[9] Such members of the team may be cited as joint wrongdoers, if without good cause their conduct contributes to the harm caused by the treating specialist, when the latter leaves the team without ensuring that another specialist is briefed to take over the patient.

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