Collaborative working: who is responsible?

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ABSTRACT

As delivery of healthcare becomes more complex, there is an increasing need for collaborative working between specialty teams. Recognition of this need has led to new models of care, for example surgeons, anaesthetists and geriatricians working together in the perioperative pathway. Although there is emerging evidence that these collaborative approaches are effective, there is little guidance on who is responsible for the patient throughout the healthcare episode. Government policy and legislation has increasingly focused on the need for a single named clinician to be responsible for the entirety of a patient's episode of care, with overall liability resting with the hospital trust as the provider organisation. This discrepancy between delivery of healthcare by teams and responsibility resting with an individual raises questions: how can clinicians and hospital trusts ensure synergistic patient care while maintaining clear lines of responsibility? Who should provide information to patients throughout the pathway? Who should the patient expect to be the point of contact? This dichotomy emphasises the need for new guidance to support the patient, the clinician and the provider organisation as shared models of care evolve and become embedded into routine practice.

KEYWORDS: Interdisciplinary teams, interprofessional relations, legal liability, patient responsibility, shared care

Introduction

Healthcare has always required cooperation and collaboration between multiple clinical teams. This has become increasingly necessary with changing population demographics, mounting complexity related to multimorbidity, rising expectation for immediate access to specialist person-centred advice and governments looking to integrate health and social care.[1,2] Many services are already delivered by well-established interdependent specialties. Often these relationships have grown organically: surgery and anaesthetics, gastroenterology and dietetics, neurology and neurosurgery. Recently, other models of evidence-based collaborative care have become routine, for example, orthopaedic surgery and geriatric medicine, obstetrics and obstetric medicine, bariatric surgery and endocrinology.[3–5] Similarly, in cancer services the need for multidisciplinary working has become apparent and resulted in doctors, nurses and allied health professionals working together.[6] However, little guidance is provided on who is responsible for the patient in such collaborative models and if care goes wrong, who may be accountable. With multiple clinicians providing advice, to whom should a patient address questions or concerns? How should clinicians and hospital trusts ensure these new collaborative models provide synergistic patient care, while maintaining clear lines of responsibility?

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Names above beds

Recent governmental policy focuses on the need for a single named clinician to take responsibility for an individual patient. In a 2015 speech, Jeremy Hunt introduced the 'whole stay doctors' initiative, in order to 'end brief encounters' and bring back 'names above beds'.[7,8] This was prompted by the 2013 Mid Staffordshire Public Inquiry, which identified failings in coordination of hospital care, suggesting 'that patients like to know "their" doctor and "their" nurse'.[9] Sir Robert Francis recommended that hospitals should be 'identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care'.[9] This has been echoed in primary care by the general medical services contract negotiation including a 'named GP' for all patients, an initiative that had already been in place since 2014 for patients over 75 years of age.[10]

Call for collaboration

At the same time as this call for 'named' clinicians, national reports are calling for more interdisciplinary collaborative working, with the aim of developing holistic person-centred rather than specialty-centred care. The Royal College of Physicians' Future Hospital Programme encourages 'shared responsibility':

> *patients may be admitted under joint consultant physician and consultant surgeon care, with junior doctors increasingly delivering care under the supervision of physicians.*[11]

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Similarly, reports from the National Confidential Enquiry into Patient Outcome and Death have repeatedly promoted joint working:

A model for the medical care of amputees, should be introduced which includes regular review by a physician and a surgeon throughout the inpatient stay.
Routine daily input from medicine for the care of older people should be available to elderly patients undergoing surgery.[12,13]

The Royal College of Anaesthetists Perioperative Medicine Programme has taken this further by suggesting a theoretical model for collaborative working to ensure that 'the patient's care is coordinated between all the relevant experts'.[14]

Further afield, hospitals are developing new shared care models with community integrated services. The Royal College of General Practitioners report, *2022 GP: a vision for general practice of the future*, discusses 'integrating generalists and specialists', working in 'organised networks of teams' – such as GP federations – and incorporating hospital services.[15]

From the patient's perspective of having multiple teams involved in their care, the National Collaboration for Integrated Care and Support co-developed a definition of integrated care with National Voices:

I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me.[16]

Notably, in this statement the patient is placed at the centre of care and indicates that professionals have collective responsibility for service delivery.

Who is responsible?

None of these proposals have been accompanied by details of how responsibility should be designated when multiple consultants are involved in the care of a single patient. Guidance from the General Medical Council (GMC) only mentions collaborative working in relation to effective communication, with its implementation neither defined nor described.[17] However, GMC guidance does address the roles and responsibilities of the single consultant, including how to refer or delegate care to other healthcare professionals. It states that clinicians who are unable to manage a clinical problem beyond their competence are duty bound to refer to others where clinically appropriate.[18] The responsible consultant has a duty to ensure referred-to colleagues have the necessary skills to provide an adequate service.[19] Importantly, consultative advice and intervention absolves the referrer from error:

You are not accountable to the GMC for the actions (or omissions) of those to whom you delegate care or make referrals. You will be accountable for your decisions to transfer care.

In comparison, the Academy of Medical Royal Colleges (AoMRC) has taken this forward, describing the duties of the designated responsible consultant providing 'overall care' – defined as delivering continuity of care and dealing with 'patient/family/carer concerns'.[20] This leaves the 'referred-to consultant' responsible only for the treatment they deliver. However, this still does not wholly clarify how close or joint working should function in routine care. The 2016 National Institute for Health and Care Excellence (NICE) guidance on multimorbidity tries to address this issue by recommending that when agreeing a management plan with a patient, you should also 'agree…with the person…who is responsible for coordination of care' and '[assign] responsibility for coordination of care and [ensure] this is communicated to other healthcare professionals and services'.[21]

Who is liable?

It is well established in law that hospitals, as provider organisations, are under a duty to provide safe systems; for example, when treating complex patients with surgical intervention, safe systems may include the hospital trust employing a team of physicians to look after the medical aspects of patient care. Where does the responsibility lie in such a team approach? Does the treating surgeon remain responsible for all decisions regarding the patient? Does this extend to decisions taken by a consultant physician on a joint ward round or in a joint clinic? Is the physician's advice classified as a specialist referral? If each consultant is responsible for their own decisions, does this include refusal to follow specialist recommendations? Who takes responsibility for transferring these discussions to follow-up in primary and social care?

This interaction is encountered frequently in the pre-assessment pathway for elective surgery. A GP, surgeon, anaesthetist and physician may all review a complex patient prior to surgery, each informing the patient of a different set of risks. The law requires doctors to inform patients of a treatment's 'material risks' – something to which the patient would attach significance.[22] For example, it is well documented that there is a risk of delirium following cardiopulmonary bypass surgery. When delirium develops postoperatively, with its associated functional and cognitive impact, who should the patient hold accountable for the failure to mention it before undergoing surgery? The surgeon is required to complete the consent form with the patient, but the duty to mention this risk may rest with the anaesthetist, or perioperative physician, who may be able to reduce the risk.

A damaged patient may be unable to successfully claim against an individual clinician, but could seek redress against the hospital for failing to provide a safe system.[23] The same is expected for other provider organisations. Lord Brooke stated 'a health authority…has a non-delegable duty to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment and safe premises'.[24]

How should clinicians share care?

From the guidance available, there appear to be three models of shared/collaborative care for clinicians working within a single provider organisation:

1. Model 1 – a responsible consultant regularly liaising with another consultant about a patient, eg obstetrician with haematologist.
2. Model 2 – a responsible consultant routinely and explicitly transferring responsibility of care for a patient to another consultant, eg orthopaedic surgeon to orthogeriatrician.

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Box 1. Considerations for local service agreement by professionals that work closely

Knowledge

- Expertise to be delivered by each healthcare specialty
- Provision of out of hours care
- Educational capacity to train junior health professionals
- Educational capacity to train nurses and allied health professionals

Attitudes

- Upholding service users/patients at the centre of care
- Forum for open discussion of error for improvement
- Understanding of pressures external to the service
- Commitment to audit and service improvement
- Commitment to local and national targets

Behaviour

- Person-centred care
- Explanation to patients of the service agreement
- Responsiveness in service delivery
- Safe handover and clinical discussion
- Sharing of complaints (and compliments)

3 Model 3 – multiple named consultants sharing care for a patient, eg surgeon and anaesthetist/perioperative physician/geriatrician.

Guidance is clear on how to manage models 1 and 2, where clear lines of referral and transfer of care exist. However, there is currently no guidance on how to manage responsibility in model 3, except that each specialist is responsible for the care they provide to the patient, with the hospital trust liable for providing a safe system. Importantly, although transfers of care may be preferable for clinicians, continuity of care is preferred by patients.[25]

The constraints of developing shared services include funding for multiple teams to provide collaborative care, the need for specialist skills in the management of complex patients and the lack of integration of IT systems for sharing information effectively. Clear lines of communication and frank delineation of care will be the key to a safe and effective service. Box 1 lists some issues that require consideration for a local service agreement between professionals that work closely.

Developing clarity

At present, there is no guidance to facilitate allocation of responsibility and accountability between clinicians working within collaborative models of care. It is beyond the remit of this article to provide such guidance; this will need collective and iterative debate between responsible organisations, such as the GMC and AoMRC, aided by legal test cases and research. NICE multimorbidity guidance has recommendations for advancing investigation in this area under the topic of 'organisation of care'.[21]

Conclusions

Current professional and legal guidance suggests a single consultant remains responsible for overall care of a patient and liability rests with the hospital trust as the provider organisation. However, as the complexity of both the patient profile and methods of healthcare delivery increase, there is recognition of the need for collaborative models of care to bring together expertise of different specialties to ensure high-quality care. These new approaches require updated guidance from national organisations on how to share responsibility and accountability between clinical teams and how to communicate this to patients and their carers.

Key points

- Collaborative working can be beneficial to patients and staff.
- Overall accountability for a patient's hospital stay remains with a single consultant.
- The hospital trust, as the provider organisation, is ultimately liable for patient experience.
- Local service agreements can ensure collaborative care is safe and effective. ■

Conflicts of interest

The authors have no conflicts of interest to declare.

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