**Vascular Society Audit and Quality Improvement Committee blog: MDT decision-making**

It is widely accepted that decision-making within the framework of a multi-disciplinary team is best practice for many patients, especially those with complex pathologies or challenging anatomy. However, as the audience of the BSET breakfast symposium at the Vascular Society AGM in Manchester discovered, making decisions in a team does not remove individual surgeons’ responsibilities.

In a session that tackled the medico-legal implications of device use in surgery, Dr Natalie Hayes, senior medico-legal advisor at the Medical Defence Union, spoke about who is ultimately responsible for MDT decisions. Using a fictitious case featuring a novel treatment and an MDT with no consensus, she explained how the General Medical Council views such situations and outlined who is responsible for the decisions that clinical teams make.

All doctors are expected to adhere to guidance issued by the GMC and a failure to do so is likely to attract criticism in the event of a complaint or investigation into the patient’s care. Perhaps surprisingly, much of the GMC’s guidance is relevant to MDT decision-making and given that we make many decisions about patient care in this setting, it is clear that we should all be aware of what our responsibilities are and what guidance applies to us as individual clinicians. Crucially, it is an individual doctor’s actions that will be reviewed and his or her individual GMC registration that is potentially at risk, even though the decision as to what to do with a patient is made by a team.

Dr Hayes explained that the basis for MDT decision-making is clearly reflected in the GMC guidance; doctors must consult and take advice from colleagues when appropriate, according to key document, *Good Medical Practice (2013)*. However, what is also clear but perhaps not so well-known is that working in teams does not alter a clinician’s personal accountability; whilst the leader of the team is accountable for the performance of the team, the responsibility for identifying problems, solving them, and taking action is shared by all of the team members (*GMC: leadership and management for all doctors (2012) para 3).*

So who is the leader of the team? The operating surgeon? The most senior clinician? The patient’s named consultant? In Dr Hayes’ experience of helping doctors facing criticism, the GMC often views the leader as the person who is responsible for checking that the patient’s best interests are considered and in practice, this would usually be the named consultant and often the same person who will be operating on the patient in fact. But Dr Hayes emphasised that that it is not possible to hide behind the MDT if things go wrong; every member of the team must be able to justify his or her decision and the role he or she plays in the MDT should the GMC come knocking.

Deciding with any certainty who ultimately carries the can for MDT decisions is extremely difficult; would the GMC investigate all MDT members, or just the team leader, or perhaps the operating surgeon? Ultimately said Dr Hayes, it is very difficult to be sure as it can depend upon the nature of any concerns and how they are raised; the key message for all MDT members is to take decisions with care, always choose the course of action that best serves the patient’s best interests, and be prepared to justify both your individual decision, and the reasons for it.

Natalie Hayes

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