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Navigating the Tension Between Collective Leadership and the Legal Accountability of the Named Consultant in Healthcare

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Introduction

In recent years, healthcare systems have increasingly embraced collective leadership as a model to enhance patient outcomes, foster interdisciplinary collaboration, and create more adaptable, resilient healthcare teams [1, 2] . Collective leadership encourages shared responsibility across team members, aligning well with the principles of integrated care and complex adaptive systems thinking. However, healthcare's legal framework, particularly in Ireland, often mandates that a single designated individual, the named consultant, holds ultimate legal accountability for patient care and outcomes. This dual structure of accountability presents an inherent tension that raises critical questions about safety, fairness, and efficacy in healthcare leadership.

The Shift Towards Collective Leadership in Healthcare

The concept of collective leadership is rooted in the understanding of healthcare delivery as a complex adaptive system, where patient outcomes depend on a range of interactions among healthcare professionals. Collective leadership allows healthcare teams to share responsibility, with leadership roles shifting according to expertise, knowledge, and situational needs. Studies have found that collective leadership can improve patient outcomes by fostering a culture of inclusion, accountability, and continuous improvement [3, 4].

In a study by Aufegger et al., researchers explored attitudes and barriers to shared leadership within the UK's integrated care system [5]. They found that both clinical and non-clinical managers recognize the benefits of collective leadership for integrated care. However, barriers such as role ambiguity, lack of clarity in accountability, and insufficient resources persist. These findings highlight the broader challenges of implementing shared leadership in systems traditionally rooted in hierarchical models. In Ireland, integrated care is promoted through the Sláintecare strategy, which advocates for team-based approaches and collaboration across disciplines to enhance health and social care integration [6]. Collective leadership aligns well with Sláintecare's objectives, as it encourages contributions from all team members, enhancing the decision-making process and reducing the risk of adverse outcomes.

The Legal Role of the Named Consultant in Ireland

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Despite the advantages of collective leadership, Irish law often emphasizes individual accountability, designating a named consultant as the legally responsible party for patient care. While the Medical Practitioners Act 2007 establishes the regulatory structure for medical practice in Ireland, it does not explicitly codify consultants' specific legal responsibilities or the standard of care expected in clinical decision-making [7]. Instead, these principles are largely derived from common law, particularly the precedents set in negligence cases.

The "reasonable skill and care" standard emerges from Irish common law, with the Dunne principles remaining the benchmark for medical negligence litigation [8]. In Dunne v. National Maternity Hospital (1989), the Supreme Court outlined that a medical practitioner is not negligent if they act in accordance with a general and approved practice accepted as proper by a responsible body of practitioners skilled in that particular field. The principles also stipulate that the practitioner must not have ignored a practice that carries inherent risks unless the benefits outweigh those risks.

This legal standard places the named consultant in a central position of responsibility for clinical decisions, even in team-based settings. Consultants are expected to oversee and guide the care delivered by the healthcare team, ensuring adherence to these established practices. While the Medical Practitioners Act emphasizes professional competence and ethical practice, ultimate legal accountability for patient outcomes often defaults to the named consultant in negligence claims, potentially undermining collaborative decision-making processes.

The Health Act 2004 [9] also outlines responsibilities for employees in public service including standards of integrity and conduct. Under this statute, the Health Service Executive (HSE) is expected to manage and deliver health services that are safe, effective, and person-centered, with clear lines of accountability. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners [10] sets out the principles of professional practice that all doctors registered with the Council are expected to follow and indicates that a doctor will have overall responsibility for treatment.

Therefore, these statutes and guidance, although encouraging high standards in healthcare, implicitly support an individual responsibility model, as consultants may be held accountable for patient care decisions that involve input from other team members.

Balancing Collective Leadership with Legal Accountability

A potential solution to reconcile these frameworks lies in revising accountability structures within the healthcare system to better reflect the collective nature of contemporary healthcare delivery. One approach could be a shift towards team-based accountability models, where responsibility for patient outcomes is shared among team members. For example, healthcare professionals could adopt a distributed accountability model, with each team member legally accountable for their own specific contributions, while the named consultant

oversees the team's collective efforts [3]. However, legal reform would be necessary to reflect this distributed approach within the Irish healthcare system.

Donnelly's *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* [11] suggests that an explicit recognition of team-based decisions, especially in complex cases, could be an important step toward reconciling individual legal responsibility with collective leadership. The *Civil Liability Act 1961* also provides some basis for rethinking collective liability by outlining how legal responsibility is assessed in cases of professional negligence, potentially allowing for distributed accountability among professionals who contributed to a decision [12].

Legal standards in Ireland could also be updated to clarify that the named consultant's role involves providing oversight and guidance, rather than serving as the sole accountable party. Documentation practices could play a key role here, with guidelines for recording shared decisions and team-based actions. Such records would ensure transparency and protect consultants from bearing the full burden of responsibility in team-based care contexts.

Policy Implications and Cultural Shifts in Irish Healthcare

To support these changes, Irish healthcare policy must evolve to recognize the value of collective leadership while ensuring patient safety. The HSE could develop guidelines to support team-based accountability, encouraging open communication and shared decision-making. Further, the HSE should advocate for protections for consultants operating within a collective leadership framework, potentially reducing the punitive culture that arises from individual accountability.

Training programs for healthcare professionals should also emphasize competencies relevant to collective leadership, including communication, conflict resolution, and teamwork. By investing in such skills, healthcare organizations can equip teams with the tools necessary for collaborative decision-making and accountability. This approach is consistent with the principles outlined in the HSE's *Integrated Care Programme for Older Persons*, which encourages interprofessional collaboration to meet the complex needs of elderly patients [13].

Discussion

The tension between collective leadership and the individual accountability of the named consultant in Irish healthcare is a complex issue with legal, organizational, and cultural implications. While collective leadership promotes collaboration, shared responsibility, and improved patient outcomes, the Irish legal framework designates ultimate accountability to named consultants, potentially undermining these advantages.

To reconcile these models, legal reforms are needed to support team-based accountability while maintaining patient safety. By aligning legal and organizational structures with the

principles of collective leadership, Irish healthcare can create an environment that fosters trust, collaboration, and transparency. Embracing collective leadership in healthcare is essential not only to improve patient outcomes but also to reduce the pressure on named consultants, enabling them to lead effectively within a supportive, team-based model.

Declarations of Conflicts of Interest:

None declared.

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References:

1. Fairhurst GT, Jackson B, Foldy EG, Ospina SM. Studying collective leadership: The road ahead. Human Relations. 2020;73(4):598-614.
2. West MA, Eckert R, Steward K, Pasmore WA. Developing collective leadership for health care: King's Fund London; 2014.
3. A. West M, Lyubovnikova J, Eckert R, Denis J-L. Collective leadership for cultures of high quality health care. Journal of Organizational Effectiveness: People and Performance. 2014;1(3):240-60.
4. Carroll Á, McKenzie J, Collins C. Medical consultants' experience of collective leadership in complexity: a qualitative interview study. Journal of Health Organization and Management. 2024;38(9):297-312.
5. Aufegger L, Alabi M, Darzi A, Bicknell C. Sharing leadership: current attitudes, barriers and needs of clinical and non-clinical managers in UK's integrated care system. BMJ Leader. 2020:leader-2020-000228.
6. House of the Oireachtas. Future of Healthcare Sláintecare Report. Dublin: Department of Health. 2017.
7. Doran K. The Medical Practitioners Act 2007: Amendment of the Medical Practitioners Act 1978-2002 in Ireland. Med & L. 2009;28:181.
8. Craven C. Medical Negligence and the Dunne Principles: The Third and Later Principles. Q Rev Tort L. 2005;1:12.

9. House of the Oireachtas, Healt Act 2004, (2004).
10. Irish Medical Council. The guide to professional conduct and ethics for registered medical practitioners. 2021.
11. Donnelly M. Healthcare decision-making and the law: autonomy, capacity and the limits of liberalism: Cambridge University Press; 2010.
12. McCartney J. CONTRIBUTORY NEGLIGENCE AND THE CIVIL LIABILITY ACT, 1961. Irish Jurist. 1961:25-35.
13. Harnett P, Williams P, Heavey C, Kennelly S, Conroy D. A Case Study in Implementing Integrated Care for Older People in Ireland; Getting from Complex Challenge to Complex Adaptation. Int J Geriatr Gerontol. 2023;6(171):2577-0748.100071.