Supervision – whose responsibility?

Dr Rehana Iqbal
Consultant Anaesthetist & Lecturer in Medical Ethics and Law
May 2017
Why me?

- Not an intensivist
- Not a lawyer

Ethico-legal considerations of teaching

Rehana Iqbal, FRCA MBBS PgDip BSc
Carwyn Rhys Hooper, Dip. Phil BSc MBBS MA
MW

- Umbilical artery catheter inserted by house officer
- Insertion supervised by registrar
- Discovered to be in umbilical vein 10 hours later
- Total blindness in one eye
Responsibility

- House office
- Supervising Registrar
- Supervising Consultant
- Reporting Radiologist
- Hospital
Potential patient questions?

- Who was the doctor? How many of these has she/he done?
- Was the standard of care poor?
- Who was supervising? Were they/should they have been called?
- Has this happened before?
- Would this have happened if someone more senior had done the procedure and/or checked the x ray?
Areas of complaint

- Poor standard of care
- Consent
  - Lack of information about operator
- Inadequate supervision
Standard of care

- Is the standard of care related to the doctor’s grade/experience?

- Should the standard of care be related to the doctors grade/experience?
Historically…….

- **Fearns v Columbia University School of Dental and Oral Hygiene**
  
  Court supported the clause in the consent form stating that the institution, doctors and students would not be liable for personal injury as “there are risks inherent in a clinical programme involving treatment by inexperienced students”

Since……………………………

- **Central Anesthesia Associates P.C. v Worthy (1985)**
  
  student nurse should be held at the standard of care of registered nurse anesthetist
The law relating to “learners” and the standard of care

- Nettleship v Weston [1971]
  Mr Nettleship was injured whilst teaching Mrs Weston to drive. Mrs W’s defence was that she could not be expected to drive at the standard of an experienced driver and the court should make an allowance for this. Court of appeal – standard applied would be that of a reasonably competent driver. To do otherwise would result in fluctuating standards.
Similarly......

- Wilsher v Essex Area HA (1986)

House of Lords

no allowance for inexperience

although recognised the need for staff ‘to train on the job’
Standard of care - key points

- Reasonable standard of care NOT best standard of care

- The standard of care is related to the task NOT experience of the doctor
  - “clinicians are responsible for knowing the limits of their own competence and should seek advice of appropriate colleagues ...” (DOH)
Consent - info about operator

Explicit consent

1. Experience of operator important
2. Increased risk
3. Legal exculpation

Implicit consent

1. Meeting with operator important
2. No greater risks
   Benefits of trainee involvement
   Duties of patients
3. Standard of care remains same
Information about “operator”
(DOH Reference Guide to consent for Examination or Treatment 2001)

- Where educational procedure is part of the treatment then assuming operator is appropriately trained there is “No legal requirement to tell the patient but good practice to do so” as nature and purpose of procedure not altered.

- States patients should be told and consented for educational procedures which are not part of their care.
“…. Department of Heath’s guidance states that patients’ specific consent is not required for procedures done by students if such procedures are part of patients’ normal care. However…. this depends on the student's competence and the risks involved.”

“patients have the right to know who is doing what to them, and how qualified they are”
Is consent by trainee essential?

- Smith v Lothian University Hospitals NHS Trust [2007]

- Consultants are responsible for teaching trainees not only the science and practice of anaesthesia but also all the other attributes that make a good anaesthetist.

(Consultant trainee relationships a guide for consultants AAGBI 2001)
Key points – information about operator

- Good practice to provide all information which patient would want
- No legal exculpation - Standard of care must be maintained
- Essential that trainee meets patient
What is Clinical Supervision?

- Definition
  - “the action or process of watching and directing what someone does or how something is done”
  - “the act of overseeing”

- Types of supervision
  - Direct vs indirect (Immediate/local/distant)
  - Adequate vs appropriate
  - Routine vs responsive vs backstage
Purposes of clinical supervision

- Support learning and development of supervisee
- Maintain quality patient care
- Support organisational effectiveness and efficiency
- Support ongoing learning and development of the profession

Clinical supervision in the medical profession: Structured Reflective Practice. Owen and Shohet. 2012
No legal definition of appropriate supervision

- AoME
- GMC
- NACT
- BEME
- RCSEd
Standards for trainers
Proposed trainer journal

- Trainer profile
- Trainee feedback
- Peer/TPD feedback
- Assessments conducted
- Reflective notes
- Documentation of training activities

- Is there a distinction between a trainer and a supervisor?
Responsibility

Trainee
- R v Prentice [1993] 4 All ER 935 CA
- R v Misra & Srivastava [2004] EWCA 2375

Supervisor
- R v Sullman [1994] QB 302
- Parmelee v Kline, 586 So. -1991

Organisation
- R v Southampton University Hospitals NHS Trust 2006
- Smith v Lothian University Hospitals NHS Trust [2007]
- Arthur Ash v. New York University Dental Center 1990
- Maidstone and Tunbridge Wells NHS Trust –acquittal 2016
Determining appropriate supervision is case specific

Considerations
- trainee ARCPs or equivalent competency documents
- regular departmental trainee review - documented
- induction processes and local guidelines
- national guidelines/expert witness statement
- (Appropriate trainer/supervisor)
Summary

- Patients managed by teams

Consider

- Organisation
  - Staffing, environment, equipment, induction

- Supervisor
  - consider the capability of the supervisee

- Supervisee
  - know when to call and whom to call

- Patient
  - receives a reasonable standard of care
  - receives information
“Not all patients need to be seen by a consultant, but it is the responsibility of the consultant to ensure that trainees only work within their own level of competence and know when to seek the advice of a senior colleague.

These problems cannot be addressed by individual doctors, but require careful planning by clinical teams and trusts.”

Ian Martin, lead clinical coordinator
NCEPOD