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Responsibility for Supervising Medical Students and Postgraduate Trainees

Note re. Guidelines and Policies

This document is a physician **guideline** approved by the Council of the College of Physicians and Surgeons of Nova Scotia.

Guidelines contain recommendations endorsed by the College of Physicians and Surgeons of Nova Scotia. The College encourages its members to be familiar with and to follow its guidelines whenever possible and appropriate. Note that guidelines may contain references to College policies.

Policies reflect the position of the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are expected to be familiar with and to comply with College policies.

Preamble

Over the past few years the College of Physicians and Surgeons of Nova Scotia (the College) has been made aware, through the complaints process, of medical errors which involved, at least partially, inadequate or inappropriate supervision of medical students and postgraduate trainees.

Medical students and postgraduate trainees are associate members of the College. The College recognizes that in order to become competent licensed physicians, students and postgraduate trainees require supervision, assessment and graduated hands-on experience and responsibilities during their education and training. The College also understands that postgraduate trainees may act as supervising physicians of those more junior. It must be remembered, however, that "[t]he education and training of all healthcare professionals should be imbued with the idea of partnership between the healthcare professional and the patient." (Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995, Command Paper: CM5207 (http://www.bristol-inquiry.org.uk))

The College also recognizes that the university training programs (in conjunction with the Royal College of Physicians and Surgeons of Canada [RCPSC] and the College of Family Physicians of Canada [CFPC] have the responsibility of providing the education, supervision, assessment and hands on experience, and that the requirements may need to be different from program to program. In the course of providing the setting for education and training, the hospitals, ambulatory facilities and individual physicians collaborate with the university in delivering the university training programs.

In addition, the College recognizes that patients' rights to refuse their involvement in clinical teaching must be respected. The College has the responsibility, with others, to see to the best of its ability that medical errors are decreased and patient safety preserved. Because inadequate or inappropriate supervision of medical trainees can occur and lead to medical errors, the College has developed guidelines for medical supervision, which it hopes will prevent some of the medical errors of which it has been made aware.

This document is intended to complement guidelines and by-laws already in place for training programs. It is not the intention of the College to usurp the responsibility of the training programs. The College uses basic principles of supervision for all trainees.

By creating guidelines the College is making a statement of the importance of graduated supervision for medical students and postgraduate trainees.

Principles

General Responsibility of Supervising Physician

- Maintains professional relationship with trainee at all times.
- Is cognizant and abides by standards and guidelines of the College, RCPSC, CFPC; Dalhousie Faculty of Medicine regulations, policies and guidelines and any relevant affiliation agreement with health care facilities and District Health Authorities (DHAs).
- Permits delegation of practice and decision making to the trainee only to an extent that is justified by the competence and experience of the trainee.

If there are successive levels of delegation, then the last to delegate is responsible (ie. the supervisor) for the supervision of the trainee. The role of the "Responsible Attending Physician" cannot be delegated.

General Responsibility of Trainee

- To report information to (notify) supervisor in timely fashion in accordance with the principles of notification (see below).
- To clearly indicate to patient (or responsible family member) name of most responsible attending physician and that he/she is a trainee.
- To maintain a professional relationship with the supervisor at all times.
- To be cognizant of and abide by standards and guidelines of the College, RCPSC, CFPC; Dalhousie Faculty of Medicine regulations, policies and guidelines and any relevant affiliation agreement with health care facilities and District Health Authorities (DHAs).
- To provide the supervisor with relevant information as to their experience and training as it may relate to the case at hand so that a reasonable supervisor can make a decision about appropriate delegation of clinical authority.
- To document and keep the supervisor informed of his/her actions.

Principles of Notification

This is a general outline to supplement current custom, recognizing variations between disciplines and services.

1. Responsible physician is promptly notified of any patient admitted to hospital under elective or emergency situations. - Name of responsible physician should be given by the trainee or designate to the patient and relatives during the admission.
2. Responsible physician is promptly informed of any significant change in the patient's condition; whenever an unusual or unexpected finding is observed; whenever the diagnosis or management is in doubt; prior to the undertaking of a procedure or therapy which has the potential for immediate or future serious morbidity.
3. Responsible physician is notified prior to a patient's discharge from an emergency department, ambulatory setting, or hospital inpatient service unless such discharge has been previously approved either for that particular patient or for a category of patients for which the trainee has demonstrated competence.
4. Responsible physician is promptly notified of significant requests by patient and/or relatives that may affect patient care.
5. Recognize that in certain emergency situations prior notification may not be possible.

Type of Notification

In order to prevent or minimize any potential problems, notification should be documented in the patient chart by the trainee or designate.

Teaching Procedures and Techniques

Medical students and postgraduate trainees must be taught to perform technical procedures (eg. catheterizations, biopsies, electrocardiograms, endoscopy) and various techniques (including interviewing patients and performing physical examinations) on patients.

The Learning Curve (see Appendix A)

It is recognized that every physician experiences a "learning curve" for any procedure or technique. The reports of the Pediatric Cardiac Surgery Inquest in Winnipeg, Manitoba (The Report of the Manitoba Pediatric Cardiac Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994, Associate Chief Justice Murray Sinclair. http://www.pediatriccardiacinquest.mb.ca) and the Bristol Inquiry in the UK (Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995, Command Paper: CM5207. http://www.bristol-inquiry.org.uk) made both comments and recommendations in this regard. To quote the Winnipeg Inquest "[T]he concept of a learning curve can be abused. There should be no allowance for a learning curve where patient safety is concerned…[I]nitial patient selection ought to have been restricted to those cases that promised the best results during the period of time that individual…experience was gained." The same can be said regarding the learning of any new diagnostic or therapeutic procedure by medical students and postgraduate trainees.

Therefore, the teaching physician (who may include a postgraduate trainee or fellow) should ensure that [s]he:

- Is competent in the procedure or techniques.
- Is competent with the particular implement or instrument used in the procedure.
- Supervises the procedure or technique until the student or postgraduate trainee has obtained and demonstrated the necessary skills. [S]he should be immediately available to intervene if necessary.
- Has properly selected the patient on which to teach the procedure or technique.

Patient Selection for Teaching Procedures and Techniques

1. The patient is notified of their possible involvement in educational activities prior to or on admission to the facility.
2. Informed consent has been obtained for the involvement of students or postgraduate trainees. Where it is not possible to obtain consent, the student's or postgraduate trainee's involvement should only be permitted if at the time they are part of the healthcare team directly responsible for the care of the patient, and only to the provision of necessary care. (See Appendix B for a discussion of Informed Consent and the judicial reasons from the Winnipeg Pediatric Cardiac Inquest)
3. The patient has been informed if a significant component of a diagnostic or therapeutic procedure is to be performed by a student or postgraduate trainee and whether that procedure will be performed under the supervision of the responsible physician or whether it will be performed independently and not under direct supervision of the responsible physician. (The Quebec Superior Court blamed a surgeon in 1992 for having entrusted the major part of a surgical procedure to a postgraduate trainee without having obtained the patient's consent)
4. Adequate follow-up of the procedure is available and provided, where appropriate, eg. radiologic confirmation of instrument placement.

Summary

Medical students and postgraduate medical trainees cannot be adequately trained without the participation of patients. These guidelines are intended to promote patient safety in medical training, to recognize the roles and responsibilities of supervising physicians and trainees, and to recognize the principles of appropriate participation of patients in this training.

Appendix A

Excerpt from the Report of the Manitoba Pediatric Cardiac Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994, pgs. 472-475.

Misusing The Concept Of A “Learning Curve”

Finding: The Evidence suggests that the acceptance of a learning curve muted the degree of concern that Drs. Odim, Giddins and Wiseman should have had when surgical nurses and anaesthetists voiced concerns about surgical results.

The question of a 'learning curve' needs to be placed in a proper context.

Neither Blanchard nor Bishop (the department heads responsible for the program at the relevant time), the cardiologist nor the surgeons gave appropriate consideration to the fact that junior surgeons (such as Odim) and newly established (or re-established) surgical teams experience a learning curve. This learning curve is a recognized fact. Indeed, it was precisely because of the concept of a learning curve that many witnesses expressed a concern that the Pediatric Cardiac Surgery Program at the Children's hospital was not able to perform enough operations to allow team members to establish and maintain their skills at a high enough level.

To that extent, there is a validity to the consideration of a learning curve for individuals and teams. However, the concept of a learning curve can be abused. There should be no allowance for a learning curve where patient safety is concerned or when analyzing results of surgery. While witnesses before this Inquest said that they recognized that a learning curve has no place in determining the acceptability of poor surgical results, there was a noted tendency on the part of some, in defending the events of 1994, to point to what they considered similar 'results' at the start of Dr. Kim Duncan's career in Winnipeg. This was apparently used as a rationale for believing that there was no need to be alarmed about what was occurring in the Pediatric Cardiac Surgery Program in Winnipeg in the spring or fall of 1994. That was simply not an appropriate use of the concept of a learning curve.

The evidence does establish that surgeons and surgical teams have the potential to have higher morbidity and mortality rates in the early stages of their development. These rates are likely to be higher if the program in which they are functioning does not go through a carefully planned and initiated start-up, if it is not properly and closely monitored and if steps are not taken to identify and resolve problems and improve performance. That fact should have caused those in charge of the program to have taken two major steps before the start-up of the program in 1994.

First, an effort should have been made to ensure that an experienced person was in a position of authority in the program to provide guidance with respect to start-up issues that the program was inevitably going to face.

Secondly, those in charge of the program ought to have been careful to ensure that the new surgeon and the restarted program were closely monitored at least throughout the first year. Initial patient selection ought to have been restricted to those cases that promised the best results during the period of time that individual and team experience was gained. The evidence suggests that, unfortunately, few steps were taken to ensure that the program did not take on cases that were beyond the capabilities of either the surgeon or the team as a whole throughout the year. Those in charge of the program acted on the basis that poor surgical results would simply improve over time. That was simply not appropriate.

Blanchard and Bishop, the department heads responsible for the program at the relevant time, Giddins, the cardiologist, and Odim the pediatric cardiac surgeon, all bear some responsibility in that they failed, individually and collectively, to ensure that the program was restarted on a carefully phased basis.

Administrative Issues

Finding: The evidence suggests that Drs. Blanchard and Bishop, the department heads responsible for the program at the relevant time, did not address the underlying issues that led to the departure of Collins and Duncan. Instead, the program was placed in the hands of a relatively inexperienced cardiologist and an even more junior surgeon who had just completed his training.

Two key members of the program's medical staff, Dr. George Collins and Dr. Kim Duncan, resigned from the Variety Children's Heart Centre in 1993, in part, because they believed the centre was not receiving sufficient support from the HSC. While the lack of support they mentioned was partially related to finances, the issue seems to have been related primarily to whether or not the hospital was prepared to support the program in a manner that allowed it to meet the objectives and standards that both Duncan and Collins had set for it.

Finding: The evidence suggests that Drs. Blanchard and Bishop failed to recognize that, in light of the significant changes in personnel at the Variety Children's Heart Centre, the lack of experience of the new leadership of the Pediatric Cardiac Surgery Program, and the fact that the cardiologists who had left the program in the previous year and a half had not yet been replaced, the program would require close supervision and monitoring in early 1994.

It would appear that the budgetary and administrative changes undertaken at the hospital during 1993-94 were a significant distraction for the department heads and other supervisory staff. Given those demands during this period, it is conceivable that the department heads did not have the time to provide the necessary leadership for a program that was being restarted. If that was so, Blanchard and Bishop should have recognized that and should have considered delaying the program's restart.

Finding: The evidence suggests that Drs. Blanchard and Bishop furthermore did not prepare for or have in place a proper orientation for either a new surgeon or a new director of the VCHC. Giddins was assigned interim responsibility for the position vacated by Collins, but there is no evidence that he was prepared for the duties he was assigned.

Finding: The evidence suggests that Drs. Blanchard and Bishop, along with Giddins, also did not ensure that there was either formal or informal mentoring of Odim upon his arrival at the HSC. In the case of a young surgeon in his first appointment following his residency, more careful consideration ought to have been given to the fact that he was facing an entirely different experience from what he had faced as a surgical resident.

Finding: The evidence suggests that Drs. Bishop, Blanchard and Giddins also did not ensure that anyone was assigned responsibility or took responsibility for building and mentoring the Pediatric Cardiac Surgery team as a whole in the early part of 1994. Without this leadership, the problems that arose in the early operations rapidly led to unresolved – and, in the end, unresolvable – conflicts.

As a result of the lack of appropriate orientation and mentoring, the program was plagued throughout 1994 with a variety of very serious problems. HSC operating-room and ICU staff were not properly prepared for Odim's particular approach to surgery and post-operative care, while Odim often made assumptions based on his limited experience at other institutions. Examples are numerous and are found in the preceding chapters. These problems may, in fact, have compromised patient care.

Finding: The evidence suggests that Drs. Bishop, Blanchard, Giddins and Odim did not give sufficient consideration both to Odim's lack of experience and to the level of team development.

Finding: The evidence suggests that the lack of supervision and the lack of a phased start-up plan meant that the Pediatric Cardiac Surgery Program was marked by poor case selection in 1994 and that the program undertook cases that were beyond the skill and experience of the surgeon and the team.

Finding: The evidence suggests that the cardiologist and the surgeon did not take appropriate steps to establish and maintain open and ongoing lines of communication with other related medical services in the hospital, such as nursing and anaesthesia.

Additionally, one of the factors that increased team dysfunction was the surgeon's use of techniques and approaches with which other team members were not familiar and for which the surgeon did not prepare them. The surgeon seems to have erroneously assumed that everyone knew what he was talking about. In some cases there was a lack of sufficient consultation and briefing before the team undertook specific, complicated procedures. For example, it would appear that the neonatal intensive care unit staff were not sufficiently briefed and prepared by the surgeon, or the cardiologist, for the patients undergoing Norwood procedures.

Recommendations

It is recommended that: The Health Sciences Centre develop protocols for providing orientation and support to all new staff and staff moving into new positions. This should be done even when the appointment is to an Acting position.

It is recommended that: Any re-established Pediatric Cardiac Surgery Program involve all units that would be affected by the program in the development of appropriate protocols. Such protocols should include a requirement that the entire team, including those individuals responsible for post-operative care, be fully prepared before the program moves to higher-risk cases or new procedures.

Appendix B

Excerpt from the Report of the Manitoba Pediatric Cardiac Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994 , pgs. 479-481.

Treatment Of The Families

The families of the children who died in 1994 put their faith and the lives of their children into the hands of our health-care system. As indicated at the outset of this chapter, the evidence suggests that these children did not always receive the standard of care that their parents had every right to expect. The preceding findings and recommendations have addressed the reasons why the system failed to provide and appropriate level of care. However, there are a number of findings that must be made about the way parents were and were not informed about matters that were of the utmost importance to them.

The Issue of Informed Consent

Finding: The evidence suggests that the parents of the children involved in these cases were not as fully informed as they were entitled to be when asked to give consent to surgery on their children.

Patients and family members granting consent on behalf of a patient are entitled to know the risks involved, before they give their consent to surgery. However, there was clear disagreement over the sort of information that must be shared.

The experience of the surgeon and the team

A number of the medical witnesses felt that declaring one's medical experience is not a requirement for informed consent, while many of the parents felt strongly that they should have been provided with more information about the program and about the surgeon's experience.

Many hospital staff seemed to feel that it was appropriate to describe the surgeon as highly trained, or 'one of the best', and to state that the Winnipeg program was 'as capable as anywhere else'. Yet they also felt it would have been inappropriate to tell the families that Odim had not performed any of the procedures he proposed in 1994 without supervision. How one could feel free to do the former while not feeling obligated to do the latter is a matter of some concern.

Some witnesses felt that the patient or parent is owed the truth if a question about previous experience is asked, but that a doctor can remain silent on the same point if the patient or parent does not ask. While the obligation to tell the truth is obvious, it seems illogical that some would see the obligation to be truthful as not encompassing an obligation to disclose a relevant fact.

While it might not be necessary to disclose a surgeon's abundant experience at performing a particular procedure, a surgeon's lack of experience is clearly a fact that is relevant to the question of whether or not someone would be willing to entrust his life, or the life of his or her child, to that surgeon. For that reason alone, such information ought to have been disclosed without prompting.

Information about surgical risk

Furthermore, the risk factors that were cited to parents for the procedures undertaken by Odim in 1994 were not based on the facts of the situations that the children actually faced in Winnipeg.

In many cases the indications of risk that were given to the parents were reflective of profession-wide risk, rather than the level of risk for the procedure at the HSC. Information such as the relative inexperience of the surgeon, and the fact that he would be performing the procedure in an unsupervised setting for the first time in his career, was not factored into the risk assessment shared with the families. This information should have been included when determining what risk level to advise the parents was associated with the operation on their child.

All the available data clearly suggest that there is a risk factor attached to a surgeon's experience. While that risk factor diminishes with experience, the fact that it is clearly higher with inexperience ought to have been disclosed to the parents, along with an indication as to what was applicable with Odim. Additionally, the state of experience and level of functioning of the surgical team was not, as it ought to have been, factored into the assessment of risk.

Information about the May 17 withdrawal of services by the anaesthetists

All parents whose children underwent operations after May 17, 1994, should have been informed about the anaesthetists' withdrawal of service on that date. As well, parents were entitled to be informed of the decision to perform only low-risk procedures thereafter, and the decision to resume full service in September 1994.

Information about the Williams and Roy Report and the February 1995 suspension of the program

Parents also should have been made aware of the Williams and Roy report and should have been allowed to read it. Additionally, parents should have been contacted and informed of the decision to suspend the program in February 1995, before that decision was made public.

Recommendation

It is recommended that: The Department of Health of the Manitoba Government prepare a patient's rights handbook that, among other things, deals with the issue of informed consent. That handbook should clearly set out that a patient and a parent acting on behalf of a minor have a number of rights, including, but not limited to:

The right to be fully informed before giving consent to medical treatment;

The right to information about a surgeon's experience in performing a particular procedure, as well as the experience of the hospital and/or surgical team;

The right to a second opinion;

The right to an out-of-province referral in certain circumstances, including where the patient or parent chooses to have a procedure performed by a surgeon or institution with more appropriate experience and where the surgeon or institution in Manitoba lacks the same experience; and

The right to have an out-of-province surgeon perform the procedure in Manitoba, provided that there is a surgeon willing and able to do the procedure here.

It is recommended that: The Department of Health direct Manitoba hospitals to require that, as part of their obligation to obtain informed consent from a patient, hospitals have a positive obligation to provide a patient, or a parent on behalf of a minor, information about:

The right to information about a surgeon's experience in performing a particular procedure as well as the experience of the hospital and/or surgical team;

The right to a second opinion;

The right to an out-of-province referral in certain circumstances, including where the patient or parent chooses to have a procedure performed by a surgeon or institution with more appropriate experience and where the surgeon or institution in Manitoba lacks the same experience; and

The right to have an out-of-province surgeon perform the procedure in Manitoba, provided that there is a surgeon willing and able to do the procedure here.

It is recommended that: The HSC review its policies on consent and communication with families. All information that is germane to a child's care or to decisions that must be made about a child's care should be provided to those from whom consent is being obtained. In particular, the policy on consent must make it clear that the medical staff treating a patient must be forthright and truthful in disclosing all relevant information to the patient or representative before the procedure in question. The fact that a surgeon has not performed a particular surgical procedure on his or her own in an unsupervised setting in the past must be disclosed.

Document History

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