3.1.1 Competent Practice: Obligations of Individuals, Teams and Institutions to Provide Competent Care

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Educational Objectives

1. To introduce the concept of competence as an ethical obligation of professionals.
2. To introduce the concept of team and institutional competence.
3. To clarify the obligations of professionals and institutions to perform competently.
4. To provide recommendations for strengthening professional and institutional competence.

Case

Dr. Axon is hired to start a pediatric neurosurgery program at a small academic health sciences centre. His résumé demonstrates that he is a highly intelligent candidate who has recently been a fellow at a respected neurological institute. He embarks on a program of complex operations, for which he proves to be ill-prepared. Following a series of tragic deaths, and a prolonged period of moral anguish and uncertainty within the operating team, the anaesthesia and nursing staff refuse to work with him. The program closes, forcing the families of children in need of neurosurgical treatment to travel long distances for care. A thorough investigation reveals hypo-competent performance by the surgeon and the institution, which failed to validate Dr. Axon's competence.

Questions

1. What obligation does a training institution have for the competence of its professionals?
2. What obligation does a hiring institution or group have for the competence of its professionals?
3. What is the standard of competent performance for trainees and recent graduates?
4. What is the trainee obliged to disclose regarding competence and experience when entering practice?

Discussion

Competence to practice includes knowledge, judgment and skill. Knowledge must be timely and appropriate. Judgment should be balanced and attentive to the particular needs and circumstances of the individual patient—choosing the right treatment for the right patient at the right time. The physician should have sufficient skill to perform the required diagnostic and therapeutic interventions with a high probability of benefit and a minimum risk of harm or complications.

Individual practitioners have an ethical obligation to provide competent care, based on their status as professionals (i.e., those who render professional services). Professionals have knowledge and skills that other members of society lack. They are obligated to use such knowledge and skills for the benefit of society.\(^1,2\) There is generally a continuous increase of knowledge, skill and judgment during training and practice. A threshold is recognized at the point on this continuum when a trainee is judged to be competent to practice independently. This seeming break in the continuum separates the categories of trainees and practitioners. The threshold is defined by program directors and certifying boards.

The decision to certify is based on written and oral examinations, combined with a written recommendation from the residency program director that the candidate is competent to practice as an independent specialist. While there is fairly clear responsibility for these judgments, accountability is less well defined. As with virtually all educational institutions, residency programs are not held accountable in law for the mistakes or misdeeds of their graduates.\(^3,4\) Certifying boards are similarly exempt. The reputation of a training program, the trustworthiness of its director's recommendations, and the safety of future patients depend on the reliability of the director's recommendation. Accountability for competence related to fellowship training following residency is more elusive.

Licensure boards verify the credentials provided by educational institutions and certifying boards and check for criminal behaviour or censure in other jurisdictions. They do not examine practitioners' competence unless
complaints are registered by colleagues or patients. Licensure boards have statutory power to receive and investigate complaints of incompetence. They may dismiss claims, suspend licenses, restrict practice and mandate retraining.\(^5\) This leaves a wide range of practice open to moral lapses within legal boundaries, guided only by the moral compass of the practitioner and the expressed or unexpressed opinions of peers and co-workers. The Canadian Medical Association Code of Ethics is similarly unexacting, recommending only that physicians, residents and medical students "take all reasonable steps to avoid harm to patients," disclose harms when they occur (section 14), "recognize [their] limitations and when indicated, recommend or seek additional opinions and services" (section 15).\(^6\)

Informal, collaborative, intra-professional efforts to strengthen and improve performances and outcomes have proven effective in cardiac\(^7\) and vascular\(^8\) surgery. Structured efforts to improve multidisciplinary peri-operative, orthopaedic, and critical care have recently been introduced in Ontario, emphasizing coaching and the sharing of expertise among institutions.\(^9\) These supportive, collegial approaches have been enthusiastically accepted by practitioners and administrators where applied, but are still uncommon.

**Q1. What obligation does a training institution have for the competence of its professionals?**

Those responsible for the training of professionals have an ethical obligation to provide society with trustworthy, competent practitioners. They have the opportunity to assess the knowledge, judgment and skill of their trainees on a continuing basis, usually over several years of progressively increasing, graded responsibility for patient care, an option that is not available to certifying examiners. Trainers' nuanced understanding of strengths and limitations within the spectrum of competent practice should be communicated clearly to trainees. Gaps in knowledge and skill deficiencies that escape detection by certifying examinations should also be communicated to future employers and associates. This is generally done only on confidential inquiry, a critical weakness in the system. When viewed as opportunities for future improvement, deficiencies can be addressed and remedied as the practitioner continues to develop.

**Q2. What obligation does a hiring institution or group have for the competence of its professionals?**

Those responsible and accountable to society for the safety of health care at the institutional level have an obligation to verify the competence of practitioners under their supervision or employment. Failure to fulfill this ethical and legal obligation is a violation of the trust placed in hospital authorities by their community.

The surgeon-in-chief, conspicuously absent from the case description, is responsible to the community for the safety of the operating room and the competence of surgeons on the staff.\(^10\) Surgeons-in-chief verify the credentials of surgeons. Each year, the surgeon-in-chief submits to the hospital's trustees a list of operative procedures that they judge to be appropriate for each surgeon to perform. The trustees are representatives of the community, entrusted with oversight of hospital facilities. On the basis of the recommendations from the surgeon-in-chief and the medical advisory committee, the trustees grant surgeons the privilege of performing the recommended procedures in their facilities. Their responsibilities are generally specified in hospital bylaws, in accord with the Public Hospitals Act.\(^11\) Surgical colleagues share in the responsibility to report deficiencies in competence, based on the trust accorded to them as members of their profession.

Oversight of institutional competence is conducted through periodic peer reviews in the process of accreditation. Accreditation Canada provides formal inquiries for institutional leaders to use for self-assessment, verifies their assessments, and sets standards and timelines for improvement. The focus of the accreditation process is on administrative procedures and facilities (e.g. information technology, plant cleanliness, documentation) and safety. Accreditors do not survey the outcomes of surgery or the performance of individual surgeons, but require assurance that departments or programs have a process for monitoring adverse events. Public and quasi-public agencies, task forces or networks are formed in response to specific public concerns (e.g., Ontario's Cardiac Care Network and Cancer Care Ontario). Their emphasis has been primarily on access to services rather than technical competence.

**Q3. What is the standard of competent performance for trainees and recent graduates?**

Trainees and recent graduates are legally and ethically obligated to provide care at the level of competence expected of members of their profession at their stage of development. Specialty residents are held to the same standard expected of the average specialist in their field.\(^12\) The level of technical skill and endurance of senior and graduating residents, honed through years of training, approaches or may even exceed that of their seniors. However, their experience and judgment are generally less developed.
Trainees should be taught to acknowledge, manage and remediate deficiencies in their knowledge, skill and judgment. In practice, as in training, they should compensate for any deficiencies in skill and judgment through consultation with or direct assistance from more experienced colleagues. Trainee errors should be discussed with supervisors and managed by appropriate treatment, system improvement and remedial training. Disclosure of errors to patients, based on immediate or future consequences, should be conducted skilfully and humanistically under the supervision of the staff physician to minimize anxiety and conflicting interpretations.

Q4. What is the trainee obliged to disclose regarding competence and experience when entering practice?

Like trainees and experienced practitioners, recent graduates should disclose their qualifications to perform the proposed treatment. They can cite the experience and proficiency of their institution and team as a reassuring component of disclosure in the consent process. The courts have found that operative experience in training is as valid a grounding for a claim of competence as experience in practice. Prudent judgment should be exercised about the initial choice of elective cases. Complex and challenging procedures should be deferred or referred until the routines, mutual confidence and competence of the team have been established.

An excessive emphasis on autonomy and "competence to practice as independent specialists" is exaggerated in the training of surgeons. In the current practice of surgery, no one can perform an operation of any significance alone. Scheduling an operative procedure that overwhelms the competence of the team violates the rights of team members to be respected and supported in their professional roles.

The case revisited

The primary responsibility for Dr. Axon's poor judgment and wrong decisions is his own, although his superordinates, colleagues and subordinates share in the moral obligation to protect vulnerable patients who trust the institution and the profession to provide competent care. In taking on cases beyond his level of competence, he violated the trust of vulnerable patients and parents who cannot assess his ability.

The hospital board and the surgeon-in-chief should ensure the competence of surgical staff through direct inquiry and continuing observation. The anaesthetists and nurses who conscientiously refused to participate in hypocOMPETENT team care took responsibility, correctly and courageously, for the competence and integrity of the operating team. Although they might perform their uni-disciplinary functions at a high level of competence, they could not discharge their fiduciary duty to provide complex integrated care.

Responsibility for the overall competence of the surgical care provided by the institution rests with the hospital's administration, relying on the judgment of the surgeon-in-chief. The failure to verify the competence of Dr. Axon is a violation of the ethical obligations of the health care organization. In a similar case, Justice Murray Sinclair provided a lucid legal analysis of institutional responsibility for competence.

Continuing medical education

Competence to continue to practice is encouraged through programs of continuing medical education. These are largely focused on didactic presentations in lectures, conferences, courses and hospital rounds, building knowledge rather than testing or building skill. In most jurisdictions, a minimum number of hours per year is usually required for continued licensure, but the choice of content is self-directed. Building new skills and learning new technologies is a challenge for practitioners. Venues for training are slowly being developed by professional societies and industrial partners, often in collaboration.

References


http://policybase.cma.ca/PolicyPDF/PD04-06.pdf.