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- Written by experienced authors in the field
- Examines complexities of clinical supervision process and factors influencing success
- An invaluable resource for all clinicians, managers, and educators

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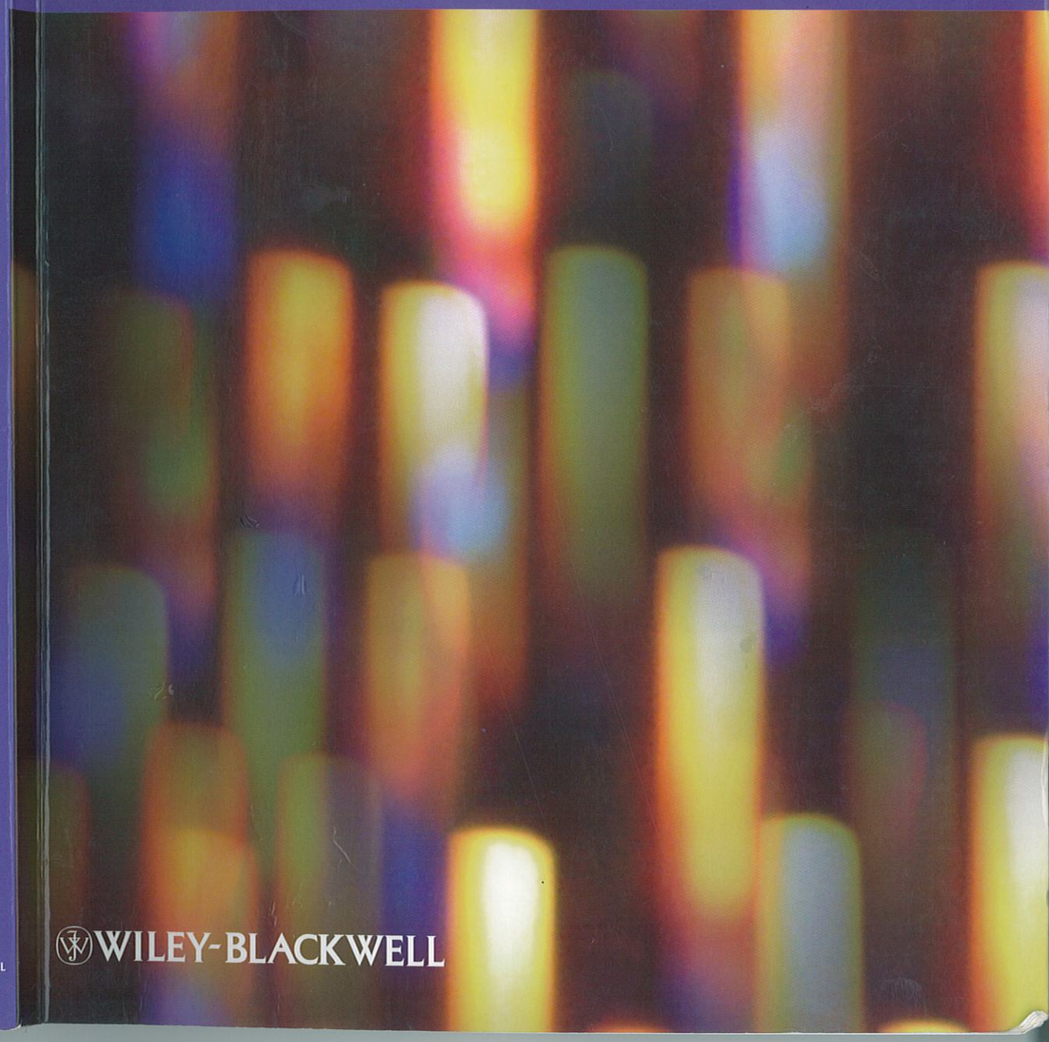

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Legal and ethical issues in clinical supervision

Introduction

Nursing is an intensely personal profession. Nurses engage with patients at an extremely vulnerable time in their lives. Many ethical issues and dilemmas arise in this context and, like other professions, nurses are required to practice within a legal framework. Clinical supervision is similarly personal and encompasses a range of ethical issues. There is, however, no specific legislation that pertains to clinical supervision, but broader legal principles are relevant to this practice. The aim of this chapter is to:

- provide a brief overview of the Australian legal system
- discuss the legal implications for clinical supervision, duty of care, negligence and vicarious liability
- consider the implications of dual relationships within clinical supervision
- discuss the importance of confidentiality
- consider ethical issues and ethical dilemmas
- consider the issue of mandatory vs voluntary participation in clinical supervision.

Brief overview of the Australian legal system

Legal frameworks govern our practice as nurses. You are no doubt already aware of the numerous Acts of Parliament that influence nursing practice. Clinical supervision is not immune from the law; however, the specific relationship between clinical supervision and the law is not clear. Furthermore, in the absence of specific guidelines to

govern the practice of clinical supervision, supervisors and supervisees must refer to the current legal frameworks for guidance.

In order to understand these legal frameworks we present a brief overview of the Australian legal system.

The Australian legal system has developed from the days of British colonisation, therefore we have adopted many of the legal principles from the British system. For example, the two primary approaches to making laws are:

- parliamentary law
- common law.

Parliamentary law

As the name suggests, these are the laws made in parliament. They are the written and formally recognised laws. They are Acts of Parliament; they may also be referred to as legislation or statutes.

In Australia's federated system we have Commonwealth or Federal Acts and State or Territory Acts of Parliament.

Health care is primarily governed at state and territory level. There are many examples of State Acts, known as Principal Acts, and many of these Principal Acts have subsequent amendments that directly affect nursing and health care, including:

- Drugs and Poisons Act
- Nurses Act
- Medical Treatment Act
- Health Records Act (replacing Freedom of Information)
- Child and Young Persons Act
- Mental Health Act
- Guardianship Act
- Occupational Health and Safety Act
- Equal Opportunity Act.

Some Acts of Parliament also have a second document known as Regulations. While the Act itself provides broad parameters and principles for the law, 'The Regulations generally give precise directions which must be followed in order to comply with the intent of the Act' (Staunton & Chiarella, 2003).

For example, the Drugs, Poisons and Controlled Substances Act of Victoria (1981) also includes a set of regulations.

State and Territory Acts may share many common principles with one another but they also vary and the specific requirements for each jurisdiction must be understood so that the implications for clinical supervision relationships can be appreciated.

For further information regarding relevant legislation go to:

Australian Capital Territory: www.legislation.act.gov.au
New South Wales: www.legislation.nsw.gov.au
Northern Territory: www.nt.gov.au
Queensland: www.legislation.qld.gov.au
South Australia: www.legislation.sa.gov.au
Tasmania: www.thelaw.tas.gov.au
Victoria: www.legislation.vic.gov.au
Western Australia: www.parliament.wa.gov.au

Judicial or common law

The concept of common or judicial law has developed from the understanding that the written word will always require some form of interpretation. No piece of legislation can ever be written with sufficient clarity to precisely define the actions or behaviours it is intended to regulate.

There is therefore a need for interpretation of the written law when the actions or behaviours vary or divert from the written law. When judges make interpretations about the law, this is known as the doctrine of precedent. Precedent represents a legal decision that is binding on any court that is lower on the hierarchy for that jurisdiction. For example, a decision made in the Supreme Court of New South Wales will be binding for the county and magistrates' courts of New South Wales. The county or district and magistrates' courts of other jurisdictions may be influenced by such a decision but they are not bound by it.

The two main forms of law in Australia are criminal law and civil law.

Criminal law refers to the regulation of specific actions and behaviours to protect the safety and security of people. Violation of this law results in punishment, and criminal behaviour is regulated by the police force. Criminal laws define unacceptable behaviours against the person, such as murder and rape, and against property, such as theft.

Civil law refers to the resolution of disputes between people that they are unable or unwilling to resolve themselves. Civil law does not fit within the responsibility of the police force. You will quite likely have seen signs on properties stating something to the effect of 'Trespassers will be prosecuted'. This statement is not accurate. Trespass is a civil law issue and as such civil action (commonly known as suing) would need to be taken to resolve this issue. Unless a criminal act such as theft or assault is occurring on the premises, the police and law courts will not become involved.

Civil law

The legal issues affecting nursing practice generally fit within civil law. The following civil issues are particularly relevant for nursing practice and therefore clinical supervision:

- negligence
- consent
- trespass against the person.

Negligence

Negligence refers to causing damage to another because of a failure to exercise reasonable care. For negligence to be found four elements must be observed (commonly referred to as the four Ds):

(1) Duty of care: the existence of a relationship that involves a duty of care by one person to another must be substantiated.
(2) Dereliction of duty of care: the expected or required standard of care was not provided.
(3) Damage, as demonstrated by loss or injury. This can be physical, psychological or economic (i.e. loss of income or earning potential).
(4) Direct – cause and effect: the breach caused or materially contributed to the damages suffered.

A claim of negligence will not be successful unless all four criteria can be demonstrated.

Duty of care

As nurses you are no doubt familiar with this term. We know that we have a professional obligation to provide safe, high-quality care to those who receive our services.

You may not know the origins of this concept. It may surprise you to know that it did not originate from the health care system, but rather arose from an everyday life incident.

The Donoghue vs Stevenson case is famous in legal circles. A lady (Donoghue) drank a bottle of ginger beer bought for her by a friend. After consuming most of the contents from the opaque bottle, the decomposed remains of a snail became evident. Donoghue took legal action for damages because she experienced shock and severe gastroenteritis. One of the particularly interesting features of this case is that according to existing civil law Donoghue did not have any legal basis for successful legal action. Had she purchased the ginger beer herself she could have sued for breach of contract as the goods she purchased were not what one could reasonably expect to receive. However, she was not party to a contract. The friend who purchased the offending ginger beer could not sue because he did not experience any untoward effects.

Indeed, the original legal action undertaken by Donoghue was not successful for this very reason – the absence of a contract. The prevailing legal argument from the appeal was that manufacturers have a duty of care to ensure that goods intended for consumption must indeed be suitable and safe for consumption. Should the manufacturer fail to ensure safety, then negligence has occurred.

Determining whether or not a duty of care exists depends on two main factors: foreseeability and promiximity. Foreseeability means that people must take reasonable care to avoid acts or omissions that might reasonably be likely to cause injury to a neighbour. In this legal sense, the term 'neighbour' is not limited to the person next door or living in the same street but rather refers to persons who are sufficiently close to be directly affected by acts or omissions. In the case of Donoghue vs Stevenson, Donoghue was regarded as a 'neighbour' of the manufacturer. Clearly the acts or omissions that led to the decomposed snail being in the ginger beer could be foreseen as potentially detrimental to whoever drank the ginger beer.

In the case of nurses, patients represent the obvious neighbours as they can readily be affected by the acts or omissions of nurses. For example, if a nurse does not administer prescribed medication (omission) or administers twice the dose of the prescribed medication (act), the patient may experience a deterioration of physical condition or even death. As a 'neighbour' the patient is affected by the act or omission of the nurse and the nurse has breached his or her duty of care.

Dereliction of duty

Where legal issues arise, the courts will consider the following in determining whether or not a duty of care has been breached:

- whether the standard of care provided is what would be expected from a 'reasonable' nurse
- whether the relevant legislation has been breached
- whether there has been a breach in relevant policies and procedures.

The use of the term 'reasonable' is common within legal circles. It focuses primarily on what actions or behaviours could be reasonably expected in particular circumstances. Although it is very difficult to define exactly what is meant by reasonable, in the case of nursing it refers to what we would describe as professional standards of behaviour. Given the examples above, one might be justified in expecting the nurse to administer the medication at the dose prescribed and at the correct time. Failure to do so might indicate the breach of a duty of care but mitigating circumstances may be considered by way of explanation.

Example

Take the nurse who does not administer the prescribed medication. An explanation that he or she forgot would probably not be accepted in a court of law. Legal interpretation is likely to suggest that a 'reasonable' nurse should not forget or, stated another way, it is the expectation of patients that they will be provided with safe care, including the accurate and timely administration of medication.

Alternatively, consider the following situation. Shaun is the registered nurse in charge of the afternoon shift in a busy medical unit. Jennifer, a 16-year-old girl, is admitted with the acute onset of type 1 diabetes. The treatment orders for Jennifer include blood glucose levels and a sliding scale order for insulin, four times a day. The next time is 4pm. At 3.45pm, a new patient is admitted with an acute phase of chronic obstructive airways disease. He is an older person who is clearly very ill and requires significant attention. At 3.55pm a patient on the ward experiences a cardiac arrest. All ward staff become involved in the resuscitation efforts. At 4.30pm, Shaun notices that Jennifer is unconscious. Her condition is serious and she is transferred to the intensive care unit. Fortunately, Jennifer makes a full recovery but her parents take legal action against the hospital for pain and suffering on the basis of dereliction of the duty of care to provide safe and timely treatment for Jennifer.

- What do you consider to be the main differences between the two situations?
- Do you consider there were mitigating circumstances for Shaun in not ensuring Jennifer's medication was administered?
- Do you think there are actions that Shaun could have taken to ensure appropriate and timely care could have been provided to all patients, including Jennifer?

Whatever your responses to questions two and three, it is very likely that you would agree that the two situations reflect different issues. In the first instance, the nurse has simply forgotten, and while we are all human, it would be reasonable to expect a registered nurse to administer prescribed treatment. The second example is not so clear cut. Clearly Shaun's ability to attend to Jennifer has been influenced by other demands within the ward environment. Whether or not these circumstances would represent a legally acceptable defence is difficult to determine; however, a number of issues would probably be considered, including:

- Should Shaun have contacted nursing administration with a request for more staff in response to the ward emergencies?
- Should Shaun have ensured that one staff member remained available to attend to the needs of other patients and ensure treatments were attended to as ordered?

The answers to questions such as these would determine whether or not Shaun had been derelict in his duty of care to Jennifer. That is, what would 'reasonably' be expected of a registered nurse in these circumstances?

Damage

This is relatively straightforward. Damage or injury must be evident if legal action for negligence is to be taken. If prescribed medication is not administered but the patient does not experience any ill-effects, there would be no basis for legal action.

Direct – cause and effect

The test that applies to determine causation is whether or not it 'is a reasonably foreseeable consequence of the defendant's negligent act' (Staunton & Chiarella, 2003: 36). This means it is not sufficient to show that damage or injury has occurred (in the case of Jennifer, unconsciousness), but this damage needs to have occurred as the result of the act or omission (failure to test blood glucose and administer insulin as prescribed).

The relationship between the cause (omission of treatment) and effect (unconsciousness) is likely to be seen as clear and obvious. However, it is important to note that Jennifer made a full medical recovery and legal action is based on pain and suffering, which is not so clearly obvious and would therefore be a matter of legal interpretation.

Policies and procedures

It is important that the distinction is made between laws on the one hand and policies and procedures on the other hand. Laws as discussed previously are enacted by state, territory or Commonwealth governments. Policies and procedures, on the other hand, are employer directives. For example, many Australian health services require that two nurses hear a telephone medication order before the medication can be given. This is a local rather than a legal requirement. The Drugs and Poisons Acts do not require this. In legal terms a court will give consideration to policies and procedures; however, if they disregard the law, are considered out of date, unobtainable or totally inappropriate the court can overrule them. Policies and procedures do not provide a defence for failure to adhere to legal expectations or responsibilities.

Example

A nurse working in a community mental health team is the only nurse on duty when an emergency phone order is required. Whilst the Drugs and Poisons Act states that only one nurse is required to hear the order the policies and

Continued

procedures of the health service state that two nurses are required for all phone orders. Legally the nurse is not prevented from taking the order; however, to do so would be breaching the health services policy.

Consider the two alternatives:

- If the nurse accepts the order he is breaching policy.
- If the nurse does not accept the order he could be found to have neglected his duty of care if damage or injury results.

If tested in a court of law the Drugs and Poisons Act for that jurisdiction would be considered as the definitive authority. Breaching the health service policy would be seen as necessary in that situation to avoid negligence.

The doctrine of vicarious liability

This concept originated from the master–servant relationship and describes the responsibility that the master had for the actions of his servants. In contemporary society it refers to the responsibility the employer holds for the actions of employees.

The basic assumption behind this concept is that the employer bears responsibility for the actions of employees where the employees operate within the bounds and expectations of their professional role. For nurses, this means that the hospital or health care organisation that employs them assumes the responsibility of providing safe and effective health care to the people who use its services.

The doctrine of vicarious liability imposes legal liability on a person or an organisation for another's wrong doing. In the case of the health care industry, the organisation may be found to be vicariously liable where:

(1) the tort or wrong doing was committed by a person as an employee
(2) the tort was committed during the time of employment.

However, there are limits to vicarious liability, particularly where employees knowingly operate outside their scope of practice. The organisation may take legal action against employees to claim damages paid or a proportion thereof when the employee's actions have diverted from what could reasonably be expected as part of their employment.

In terms of vicarious liability, as a rule:

- Organisations will support you if you have operated within your standards of practice.
- Operating outside the standards of practice could result in your organisation being sued by the person claiming compensation for your wrong doing.

- In turn the organisation may seek financial compensation from you.
- If you have breached policy, the insurance company representing the health service may sue you individually for compensation.
- Historically, nurses have not earned sufficient income for insurance companies to sue; however, that is changing as nurses now often have more assets, have higher incomes, etc.

Increasingly, professional indemnity insurance is advised to cover nursing practice. Professional indemnity may be included in the membership fees of professional and/or industrial bodies.

Reflective exercise

Check the conditions of membership of professional/industrial bodies of which you are either a member or eligible for membership:

- Do they provide professional indemnity cover?
- What amount are you covered for?
- Is that amount likely to be sufficient if a person becomes seriously injured or dies and the clinical supervision you have provided is considered to be a contributing factor?
- What are the conditions that exclude the insurance company from financial responsibility?
- Are there any provisions specifically made about clinical supervision?

Implications for clinical supervision

If clinical supervision is conducted according to the principles outlined in this book, it is unlikely that any adverse effect could be attributed to clinical supervision. As we have discussed in Chapter 1, the clinical supervisor does not (and should not) accept responsibility for the clinical practice of supervisees. Therefore, if a supervisee acts or fails to act in a manner that results in adverse outcomes, and this is claimed to have occurred as a direct result of the actions or advice of the clinical supervisor, this argument should be dismissed.

Legal action involving (either directly or indirectly) clinical supervision within nursing has not yet been witnessed in Australia. However, given the increased focus on clinical supervision for nurses it is possible that this may change in the future. If you agree to provide clinical supervision and something goes wrong you may be asked to demonstrate that you had the skills and appropriate preparation for the role and that you were not operating outside of your scope of practice. It is therefore crucial that you do not take on the role of clinical supervisor unless you feel confident and competent to do so. Education and training are essential as adequate preparation for this role and are discussed in further detail in Chapter 7.

Documenting clinical supervision

There is no legal obligation to keep process notes on clinical supervision sessions. However, we recommend that as a formal relationship, process notes are as important for clinical supervision as they are for health care and therapy.

Many people engaged in clinical supervision, particularly supervisees, do not feel comfortable about the idea of process notes. This usually reflects concern about confidentiality. It is important to remember that supervisors are likely to provide supervision for more than one person and it is therefore likely to be difficult to retain a comprehensive understanding of supervisees' issues and journeys without notes. Session notes are particularly useful in reviewing individual sessions and monitoring progress over time.

Confidentiality

While acknowledging the importance of process notes, confidentiality is likely to remain an issue of concern for many supervisees. There is likely to be concern that information about the supervisee's practice or other issues such as conflict with management or colleagues may become known to others outside of the supervisory relationship. This danger can be minimised through the way the notes are written. For example, the notes can refer to major themes rather than specific details and pseudonyms can be used in place of names.

Example

19.11.07 Notes of clinical supervision session with Mary Mathews
Clinical scenario raised today by Mary – Major themes

- Altercation with a medical specialist (KP) in relation to the involvement of a patient and her family in treatment planning.
- The patient and family had expressed to Mary (primary nurse) that they did not feel heard or listened to and wanted her support in ensuring that their views were taken into consideration.
- Mary wanted to assist her patient but was feeling unsure about the best way to do this and wanted to explore her hesitation in some detail and problem solve the ways forward.
- Mary expressed she had experienced difficulty with KP in the past and she found it difficult to approach him due to this past experience.
- Mary also expressed she did not feel able to discuss this with her nurse unit manager (NUM) as she had not found her supportive when past issues about KP were raised.

Continued

Main discussions/overview

Through the exploration in supervision Mary identified that she was slightly intimidated by KP and found him to be dismissive of her and nurses in general. When Mary had tried to advocate for her patients in the past, Mary had found that KP was 'rude, abrupt and dismissive'. Mary discussed in some detail her own issues of authority and lack of assertion when it came to people in senior roles, e.g. NUMs, medical specialists, consultants and educators.

Mary identified that she needed to find ways to assert her patients' needs even when feeling intimidated by others. Throughout the rest of the supervision session we explored the reasons behind this and discussed ways for Mary to be able to feel more comfortable expressing and asserting herself, even when there might be a negative or direct response from her seniors. She developed a dialogue she felt comfortable with and she practiced saying this to KP and also to her NUM. Mary asked to role-play the interaction. Whilst this was the first time had Mary asked to use role-play, it seemed like a very useful strategy and she seemed to really use the medium well.

Mary left the session very confident in her ability to meet with KP the following day after ward round to discuss the patient and family's requests.

Need to check in next session as to the outcome.

Steps can be taken to protect the confidentiality of process notes, including the storage of notes in a locked filing cabinet which can only be accessed by the supervisor. This may alleviate some concerns of supervisees but it is also important that they have a realistic understanding of the limits of confidentiality. Confidentiality is not absolute and can be overridden by the public interest in the case of matters involving protection of the public and/or the prosecution of a serious crime. For example, if the death of a patient becomes a matter for the coroner's court, any documentation the court considers relevant can be ordered and must be provided. This would include process notes from clinical supervision if it was considered they may contribute to the investigation of cause of death.

Ownership and storage of process notes

There is no legal requirement to maintain notes in clinical supervision. However, issues of ownership are relevant if the notes are written in work time. In these circumstances, the records of clinical supervision from within an organisation are owned by the organisation. There is no specific legislation pertaining to clinical supervision records; as clinical information is very likely to be discussed they would be treated as a health care record (MacFarlane, 2000; Staunton & Chiarella, 2003), but you should refer to your state or territory's legal requirements for health records. However, generally the organisation owns the notes. In the case of private practice, the clinical supervisor has ownership over all documentation. As with all health records, correct storage is an essential requirement. However, you may need to refer to the relevant legislation. The information you obtain needs to be discussed with the supervisee, and the expectations of the organisation employing you need to be clearly understood.

You need to spend some time reflecting on the issue of process notes. For some supervisors this is not an easy clear-cut decision and there may be some homework involved prior to starting.

Questions to be asked

- Is there an expectation from my organisation that I keep notes?
- Who owns the clinical supervision notes?
- Who has access to the notes?
- Is a locked cabinet available?
- What will happen to the notes when the clinical supervision ends?

Legal jurisdictions of relevance to nurses

Nurses may appear at or face the following courts or hearings:

- professional body, e.g. nursing registration authority
- coroner's court
- civil court (magistrates' court)
- conciliation.

Nursing registration authority

The nursing registration authorities of the respective states and territories of Australia have a responsibility to ensure that professional standards of conduct are maintained. Anyone can report a nurse to the relevant nursing registration authority on the basis of unprofessional conduct or illegal behaviour. Nursing registration authorities have the power to sanction the behaviour or actions of nurses through the cancellation or suspension of registration.

Coroner's court

The role of the coroner's court is to investigate the cause of death. Unlike other courts, a person cannot be found innocent or guilty. The coroner can suggest that people have contributed to the cause of death through statements like 'the two nurses in this particular situation contributed to this person's death by . . . administering the wrong medication'. If the coroner has concerns that the level of contribution has implications for criminal law, he or she can refer the case with the cause of death to the public prosecutor's office. However, a more likely sce-

nario is that the public prosecutor's office receives all coroners' reports and makes a decision on whether to prosecute independently.

Civil court (magistrates' court)
Magistrates' courts hear both criminal and civil cases. Only the police can prosecute under criminal law; however, private individuals can pursue civil action. Nurses may appear in civil cases as a defendant or be called in as an expert witness.

Ethical issues

What is ethics?

The term 'ethics' relates to a process of determining the moral virtue of a particular course of action. It provides the basis from which people can:

> *'. . . question why they considered a particular act right or wrong, what the reasons (justifications) are for their judgements, and whether their judgements are correct'*. (Johnstone, 2004: 11)

Ethical principles
Staunton & Chiarella (2003) describe five main ethical principles:

(1) Concern for the well-being of individuals and of society.
(2) Embodiment of ideals, that is 'what should be done' is valued over 'what can be done'. Eliminating world hunger, for example, represents an ethical stance, despite the numerous and significant barriers that mean this goal is unlikely to be achieved in the foreseeable future.
(3) Use moral reasoning to determine what is appropriate or inappropriate in specific situations.
(4) Ethical principles are applied universally and equally, to all persons at all times.
(5) Ethics is considered to be of ultimate importance, more so than the law or other influences such as politics. Ethical decisions should also prevail over individual interests. For example, those who believe in the right of individuals to die with dignity would consider assisting a person with a terminal illness to end their life to be ethically correct despite the fact that the law stipulates such a practice as illegal. Under these circumstances the individual would probably consider the law to be unethical.

An ethical dilemma occurs when you need to make a decision but you are unsure of the action you should take. For example, there may be conflict between what you know you should do and what you want to do. Or perhaps you have an apparent conflict between two sets of ethical principles or between the values you hold.

Ethical issues can affect nurses on either an individual or a professional basis. At an individual level, nurses are influenced by their own views of behaviour and actions that they consider to be right or wrong. At a professional level nurses are governed by a code of ethics. The Australian Nursing and Midwifery Council (ANMC) has developed a Code of Ethics for Australian Nurses. This document can be downloaded from the ANMC website at: http://www.anmc.org.au/docs/Publications/ANMC%20Ethics%20for%20web.pdf.

Primarily the aim of this document is to outline the importance and essential characteristics of safe and professional nursing practice.

Ethics and clinical supervision

No specific guidelines have as yet been developed in relation to clinical supervision. However, as nursing practice poses a number of ethical dilemmas it is important that this area is explored.

Due to the complexity of nursing ethics, this topic will be further explored with the use of four scenarios which address the following areas:

(1) nurse–patient relationships
(2) confidentiality
(3) group supervision – dealing with bullying
(4) providing clinical supervision internal to the organisation.

Scenario 1: Nurse–patient relationships
Shannon (supervisor) and Sally (supervisee) work in different areas of the same organisation. They have been working together in supervision for over 2 years and have a strong and productive supervisory relationship. Sally had been a community mental health nurse (case manager) for many years; she is an outgoing and popular team member who is considered by her manager and peers to be a sound clinician and a 'good nurse'. Sally enjoys supervision, finds it very useful and makes effective use of the supervision sessions. She always comes prepared with clinical situations, and is able to be open and honest with Shannon about her work.

Today's session, however, became a little more difficult for Sally when the supervisor discussed with Sally her 'connection to a patient called Shane'. Shannon highlighted that Sally talked a lot about Shane and seemed to focus on him in a different way from that of other patients. Sally was initially quite surprised by this and then somewhat reluctantly admitted that her manager had also discussed with her recently her professional boundaries in relation to Shane. She was, for example, spending considerable time with him, working back late, and having Shane as the last appointment of the day, etc. Sally admitted to

Shannon that she had not realised she was doing this, but it became obvious when the manager pointed it out.

Sally also admitted to Shannon that she had thought of bringing Shane to supervision (through the supervision process) a number of times as Shane reminded her of her ex-boyfriend and working with him had raised issues for her in relation to the break up with her ex-boyfriend. Sally also talked about how much she was really enjoying working with Shane; they were similar ages, he was not as unwell as her other clients and she gained much from their work together. Sally was not able to articulate why she had not discussed this within supervision previously.

When Shannon asked if Sally was attracted to Shane, Sally was clearly uncomfortable and quietly answered 'Yes'. Sally then very quickly stated that she knew it was not okay but had it under control, that she was professional and handling it well and also felt that she had hidden her 'secret' feelings from Shane. Sally seemed really embarrassed and talked about how she should be able to handle her feelings and not be attracted to a patient and not let it affect her work. Sally also seemed clear that until now Shane had had 'no idea' of her feelings. However, after their last session Shane had given Sally his telephone number and asked her to give him a call.

Sally admitted, again in an embarrassed and uncomfortable way, that, although she did not call him and they have not had contact since, she was struggling as part of her had really wanted to call.

Reflective exercise

(1) What are the ethical dilemmas in the above scenario?
(2) As the clinical supervisor explore each of these ethical dilemmas in detail in relation to the following:
- What would I do next?
- How would my organisation expect me to react?
- How could I support Sally?
- What supports (including administrative supports like policies/procedures) are available to support me in making these decisions?

Consider your answers to the questions above. How much of how you responded was based on fact and how much was influenced by what you think you know or what you think might have happened? It is absolutely essential in supervision that you only respond to what you are told, that you do not gap fill and assume or guess. For example, you know Sally is attracted to Shane, you know he gave her his telephone number and you know that part of her wanted to call.

In this scenario some supervisors may believe that Sally is already having an affair or disbelieve her and think she really did call him. You do not know that and to make up details based on your own imagination, bias and prejudices is dangerous.

Sally needs your support and understanding. Disclosing attraction to a patient is difficult and it would be really easy to shame Sally and make her feel like she is a 'bad nurse'. Supervisors need to put aside their own feelings of disgust, disbelief and frustration in circumstances such as these. Sally needs you to acknowledge that attractions can occur, that it is normal, at times, to be attracted to patients and the important thing is how we manage the attraction. Patients are human beings after all and attractions between humans are bound to occur at different times, even when they are not supposed to. As her supervisor, you would need to find a way to work with Sally to gently explore the issues around patient boundaries. Some of the questions you might pose to Sally include:

- What are professional boundaries?
- Why do we have clear boundaries between patients and staff?
- What are the consequences for the patient and staff if these boundaries are breached?
- Does Sally think that she has breached any boundaries at this stage?

Sally's response to these questions will depend on the way you as a supervisor continue to address this situation with her. If Sally continues to be clear that she is not to call, and that relationships with patients are not acceptable and she is able to articulate the reasons why, then you as her supervisor will be able to remain working with Sally in a fairly supportive and non-directive way. However, if Sally is unclear about professional boundaries and questions why she cannot go out with Shane, or states that she plans to call him, then you as Sally's supervisor would be likely to manage the rest of the session quite differently. You are not required to make your own subjective decision in this situation; it is not up to you as a supervisor to say whether a staff member can or cannot commence a relationship with a patient. That decision is made by professional registration bodies via codes of conduct statement/polices, organisational polices and even team-/ward-based guidelines. You as the supervisor need to use these ethical and legal frameworks to support and guide you in the work you do with Sally. You are not alone; you do not have to make these decisions alone.

In fact, you also may have identified other dilemmas or questions in this scenario for which there is no clear cut answer, for example:

- Should Shannon have raised the issue of Shane at all as supervision should be directed by the supervisee?

- Sally may become suspicious (rightly or wrongly) that the manager and supervisor had spoken together as both had raised the issue of Shane.
- How much of what Sally may raise in relation to Shane is appropriate to supervision and how much might need to be taken somewhere else? For example, unresolved issues about the break up with her boyfriend may be more appropriately explored in therapy rather than supervision.

These are all really good questions and there are no easy answers. Your explorations with Sally throughout the session will guide you and provide you with the direction you need to go in. Just remember to support Sally. This is a complex, difficult and very sensitive issue and Sally needs and deserves our support and understanding; she does not deserve to be shamed and humiliated. She also needs to feel comfortable in continuing to discuss the matter. If you show obvious signs of disapproval, Sally may stop raising the matter with you and therefore lose an opportunity for support and guidance as she works through the issue.

Scenario 2: Manager–supervisor relationships

Daniel is reading the paper in the tea room when Tricia, an NUM, enters and asks Daniel if he has a moment. Before waiting for a response Tricia loudly launches into a diatribe about her concern about a staff member on her ward named Jenny.

Tricia states she knows that Jenny sees Daniel for supervision and begins firing questions at Daniel about the supervision relationship and the supervision sessions. For example:

- Does Jenny use her supervision sessions?
- How do you think she is going?
- Have you noticed if anything is wrong with Jenny?
- Are you concerned in any way about her practice?
- What is she using clinical supervision for?

Tricia also states she has a number of concerns about Jenny and her performance and has had a number of complaints from other staff and patients about Jenny's behaviour and manner.

Daniel is clearly uncomfortable, caught off guard and taken aback by the manager and her questions. He is particularly taken aback by the intimidating way the manager is standing over him in a public place demanding a response to these questions.

Daniel asks the manager if she would like to sit down to chat about this further. He politely explains to Tricia that he is unable to discuss the contents of the supervision session as they are confidential.

Tricia is extremely dissatisfied with this reply and becomes increasingly more frustrated and visibly annoyed with Daniel. Tricia begins blaming everything on clinical supervision – she states that she understood that one of the reasons that the organisation was looking to implement supervision was to improve standards of care and to support managers and staff. Because of this she considers it reasonable that Daniel discuss Jenny's performance with her, especially if there are concerns.

When Daniel suggests the manager talks directly to Jenny and asks her how she is going, the manager raises her voice and states, 'I have spoken to Jenny, I have had her in my office on several occasions due to poor performance and complaints. I do not want to speak with Jenny, I want to speak with you as her clinical supervisor. I want to know from you as a senior member of staff in this program what is going on with *my* staff'. Tricia further expresses she is concerned she might have an incompetent staff member on her ward and that is far more serious that the 'breach of confidentiality' Daniel is hiding behind.

Tricia argues that as the manager it is unacceptable that she is 'kept out of the loop' and that clinical supervision was supposed to be about helping staff. Tricia also tells Daniel she released staff to attend supervision on the assumption that the outcomes would be favourable, but clearly it was not working as she had not seen an improvement in Jenny's performance. Whilst it was not said, there is a clear underlying threat that Tricia may remove her support for her nurses attending supervision.

Daniel then states he will talk to Jenny to seek her permission to discuss details of the supervision sessions. He hopes that Jenny would agree, but without her permission he cannot discuss the details. Daniel does state that Jenny uses the clinical supervision sessions well and always attends. Again Tricia is not happy with this suggestion and the interaction ends when the manager says she is going to be completing Jenny's appraisal in the next few weeks and will officially request Daniel's involvement.

Reflective exercise

(1) What are the ethical dilemmas in the above scenario?
(2) Do you think it is important for the clinical supervisor to keep the supervision sessions confidential and keep them focused on and driven by the supervisee?
(3) How do you feel about the way Daniel responded in this situation?
(4) Why is it important to keep managers engaged and supportive of clinical supervision? As the supervisor in the above scenario how might you do this?
(5) What would Daniel's responsibility be to the organisation if he had major concerns about Jenny's competence in supervision?

Continued

(6) What is the manager's responsibility if she was concerned about Jenny's competence? How does this relate to clinical supervision?
(7) What should Daniel do next in relation to the request/demand from the manager to be involved in the appraisal?
(8) What structures/systems should an organisation implement to reduce the likelihood of a situation like this occurring?
(9) How do you think you would respond in this situation? How vulnerable are you to managers standing over you? What if Tricia had been the opposite and politely approached you seeking your support as she was concerned for Jenny and felt that you might be able to assist her in working more effectively with Jenny and helping her out – how might you have responded in that situation?

In this scenario the most important skill is how the supervisor protects the supervisee whilst not totally alienating the manager. This is often easier said than done, particularly where the manager is being intimidating and threatening. This can often be complicated further if you are all in the same organisation and the manager and supervisor have a professional relationship outside of this discussion. Remember that while managers do not control what is in the supervision session they are instrumental in supporting the implementation of supervision and hence alienating them is not advisable. In fact, it could mean the end of clinical supervision for some or all staff in that team. Supervisors and managers must find a way to work together.

In the above scenario it was evident Tricia did not have a clear understanding of clinical supervision. She did not appear to be aware of the boundaries of supervision and the fact that clinical supervision and line management were two different functions undertaken by different people, in parallel, but in isolation from each other.

Daniel therefore needed to support and educate the manager while at all times protecting the integrity of the supervision with Jenny. This is best done by Daniel speaking in hypothetical and generalities rather than specifics. Within this education Daniel would also be able to educate the manager about the concept of clinical supervision and confidentiality and that it is not absolute. If Daniel had serious concerns, hypothetically if required he would have to support Jenny to talk to her manager. His role is to support Jenny and assist her to talk to management rather than him talking without Jenny's knowledge, but he also has certain responsibilities as a supervisor which he took seriously, just as Tricia did as the manager.

In the above scenario did you realise that Daniel actually got caught out in the end? He actually agreed to take the manager's concerns to supervision and ask Jenny if she was happy with him talking to her manager. Daniel allowed Tricia's agenda to invade Jenny's supervision. How do you think Jenny might respond? Understandably, she is likely to be distressed that her supervisor and manager are talking and perhaps even be fearful or concerned her confidentiality has not been respected. By bringing in the manager's agenda Daniel was not respecting Jenny's right to drive the supervision sessions.

This is clearly a difficult situation for Daniel but it is a not uncommon one in supervision. Organisations need to ensure that they implement clinical supervision in an informed and respectful way to protect the supervision process and ensure managers are also clear about what supervision is and is not, and how they can gain support for what is often a very challenging role. This also signifies the importance of written policies, which can serve as a useful reference point for supervisors to be able to clarify clinical supervision and its associated boundaries.

Scenario 3: Bullying raised in group supervision

Rachel has been providing clinical supervision for an inpatient medical team for 14 months. She works in a different department of the same organisation. During this period there have been a number of changes occurring within the workplace, and some conflict has emerged between team members. There has been a stable core group of nurses attending supervision on a regular basis. However, in the last 3 weeks the group have been unusually quiet, the conversation has not flowed. This session started off in much the same way, then a couple of staff encouraged others to talk and one started to cry.

Sandra starts to talk about how intimidated they feel at work because of the behaviour and attitudes of some staff members. This has got to the point that they do not want to come to work when these people are on duty. The manager does not know what is happening because they are too scared to tell him; they think this will only make things worse. Sick leave is on the rise and one staff member is planning to leave.

They describe frequently feeling humiliated in front of their peers. Rachel is concerned about the level of distress in the room and the significance of the bullying being described. The nurses feel undermined and set up. They feel the workload is not evenly distributed and some people just are not able to get through what they are given.

Rachel asks them whether they have spoken to the person concerned about his behaviour and the impact of this upon them. They indicated that one person had tried but she had been yelled at. The others did not wish to experience the same behaviour so they attempted to stay away from him as much as possible.

Reflective exercise

(1) What are the ethical dilemmas in the above scenario? Explore them in detail.
(2) How should the clinical supervisor start to explore these issues?
(3) Can you identify any complicating factors in this situation?
(4) Would the situation be different in any way if the clinical supervisor was external to the organisation?
(5) How could the clinical supervision be structured within the organisation to support Rachel managing this situation, that is who can supervise whom?
(6) Would you manage things differently in a group supervision session rather than in an individual session? If so, in what ways?
(7) What are the policies on bullying in your organisation?

It is important to keep in mind that people can often feel quite powerless in the face of bullying. They may not attempt to seek help, instead choosing sick leave or resignation. As the clinical supervisor you walk the line of listening and being supportive but not further undermining an individual's difficulty in coping by reinforcing the inability to manage the situation. The supervisor's role is to help individuals understand what the organisational structures are that may support them and help them to explore their options, providing time to develop an understanding of the consequences of the choices available. Clinical supervisors are valuable to their supervisees primarily by assisting them to explore how they might address specific issues.

For example, if you were the clinical supervisor in this example you might want to explore the perception that 'speaking with the manager will make things worse'. What is the evidence that this is the case? How do they imagine the situation would become worse?

It is very important that you are aware of what is being evoked in yourself. You may have experienced some bullying in the past and you must be able to separate your own experience from that of the supervisees. It would be problematic for all concerned if you started to direct them to a course of action that represented what you would have liked for yourself rather than what is in the best interest of the supervisees.

People need to feel supported but also to consider what they and the environment they work in contribute to the situation. For example, a nurse who is new to the role of ANUM is being accused of bullying. When the situation is investigated it appears this nurse received little, if any, orientation to the role, which suggests a lack of organisational support. The nurse is quite stressed by a lack of understanding of the role and this is expressed by being curt and snappy with other staff.

It is important to keep in mind some of the issues that are central to providing group supervision. The response to the questions you pose

and how you respond to the distress of individual group members will be magnified for the individual by the fact that it happens in front of colleagues. It may be useful to summarise at the end or encourage someone from the group to do this. This provides you with an opportunity to hear back how the discussion has been understood. You do not want to alienate people. They need to be heard but you also do not want to lose your capacity to support them through the dilemma.

You may also come under pressure to rescue group members from the situation. For example, you might offer to take an issue to the manager yourself. As an internal supervisor you are more vulnerable to these types of boundary pressures and if you have a tendency to want to rescue people or actively solve their problems (characteristics that are not uncommon for nurses) you will need to maintain your awareness of this tendency and ensure you keep it in check. It is important not to foster dependence on the supervisor or convey the message that supervisors can manage situations more effectively than supervisees.

Scenario 4: Sonya supervising within her organisation

Sonya has been working for 10 years in her current organisation; she is well known and respected by her colleagues and by management. As a result Sonya is often chosen by her peers as a clinical supervisor. Management support Sonya in this role because they recognise her as providing valuable support for her colleagues.

Sonya is supervising Kate, a nurse working in a surgical unit. She is currently undertaking her graduate year. Sonya and Kate have been working together in supervision since Kate commenced. Kate has been an enthusiastic supervisee; she has attended regularly and taken responsibility for bringing issues to discuss. In recent sessions Kate has raised concerns about her relationship with her colleagues. She has been feeling like people are not happy with her and she is not sure what the problem is. She said that she has trouble with one of the senior staff who tends to be very directive, always telling her what to do. She acknowledges that she has an entirely different style and occasionally she thinks that it is a problem but finds the constant direction hard. Kate realises that there are many ways to do things but feels they always have to be done the way this person wants it; she does not allow for any difference. Kate describes times when she has done things her way rather than the way she was told to but the outcome was the same positive outcome. Kate's concern about working with this senior staff member is that she will not learn how to think for herself or trust her own abilities. She does not want to have to rely on being directed to do something all the time.

Sonya knows Kate's manager and although they are working in different teams their paths do cross in some meetings. Sonya finds herself in the situation of hearing the manager debriefing about managing a

staff member (Kate). She found out in the meeting that it was another staff member who had reported Kate and there is a very large difference in the stories relayed. In general, there has not been any issue of concern for Sonya in her role as clinical supervisor until this moment when she learns that Kate was about to be given a warning and she finds herself in a very awkward place.

Sonya does not participate in the discussion but feels very uncomfortable and excuses herself, but she has already heard more than she is comfortable with. She has a clinical supervision session with Kate that afternoon and is very uncomfortable knowing what she does.

When Kate comes to the session she reports that the situation has improved and the senior staff member has backed off and is letting her do things her way now and she is feeling better about working with them.

Reflective exercise

(1) What are the ethical dilemmas in the above scenario? Explore them in detail.
(2) How should the clinical supervisor respond to Kate in this situation?
(3) What are the complicating factors in this situation?
(4) What is the impact of the clinical supervisor being from the same organisation rather than external?
(5) How could the clinical supervision be set up within the organisation to support Sonya managing this situation?
(6) What should Sonya's response to the manager be if any?

This scenario serves as a reminder of the need for supervisors of having their own clinical supervision to assist them to manage their feelings about being a supervisor and dealing with the inherent stressors involved. This scenario represents a possible stressor. It is the supervisee who determines the content of the session not the supervisor. As a clinical supervisor it is not your role to introduce information you hear about them or other colleagues into the sessions. As difficult as it is to be privy to this sort of information, it may be necessary to remind managers and staff broadly via the supervision coordinator of the importance of being mindful of supervisory relationships and not having conversations in front of staff that would result in placing them in the difficult position of having information about a supervisee that could potentially compromise that relationship.

As the supervisor, you may be tempted to tell Kate what you know. However, doing so would raise a range of potential implications that would be problematic. Indeed, the supervisee may become more

anxious or distressed and not know how to deal with this information. Kate may confront the manager and further fuel the conflict. It is important to ask yourself why you would consider saying anything. Is it to make yourself feel better because you do not have to hold information that is uncomfortable? This is understandable but is not a reasonable justification to take this type of action.

Mandatory vs voluntary clinical supervision

The key to addressing this issue may well lie in considering the fact that it is difficult and maybe even impossible to mandate a successful relationship. People may be forced to sit in a room together but you cannot make them talk about their work in a meaningful way. It is, however, frustrating for some that the people believed to be most in need of clinical supervision are often those who do not want it. It is understandable that this may be an issue of concern; however, it is important to consider why we may think this way and what it says about our views or understanding of clinical supervision. If by 'those who most need it' we refer to 'problem' staff, this suggests that a primary aim of clinical supervision is to work with staff who are not functioning well, almost as a form of remedial action, rather than promoting a relationship aimed at increasing understanding of and working towards the improvement of clinical practice.

Clinical supervision is therefore needed by everyone. All staff should be accessing the support they need to work as effectively and confidently as possible. This may lead to the conclusion that it should be mandatory. However, again it is important to consider how effective force or coercion is likely to be. Some organisations have dealt with this issue by describing clinical supervision as an expectation. This terminology reflects the idea that supervision is important and supported by management but falls short of insisting that it happens.

The choice of supervisor is also an important consideration. Sometimes nurses are allocated to specific supervisors. This can present a deterrent, particularly to those who are already a bit reluctant. The more people are involved in the process the more they are likely to value it and commit to it. Choosing one's supervisor is an important part of feeling involved.

Clinical supervision is a responsible role that should be taken on with consideration given to the environment that it will be conducted in and what the supports are that will enhance success. It should not be entered into lightly. As you will have seen from this chapter there are a number of complex issues that can be raised, and a clinical supervisor needs to be adequately prepared and supported to function well in the role.

Conclusion

As a profession nursing must be cognisant of the broader legal and ethical implications associated with practice and health care. Clinical supervision as a part of professional practice is influenced by legal requirements and ethical considerations. Given the absence of the legal regulation of clinical supervision, it is important that the broader expectations are considered. In this chapter, the potential legal implications of clinical supervision have been discussed. Ethical issues that may arise have also been described and considered by the use of scenarios representing situations that may occur in practice. The issue of whether clinical supervision should be mandatory or voluntary has also been examined.

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