The Superguide

a handbook for
supervising doctors in training

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FIRST EDITION
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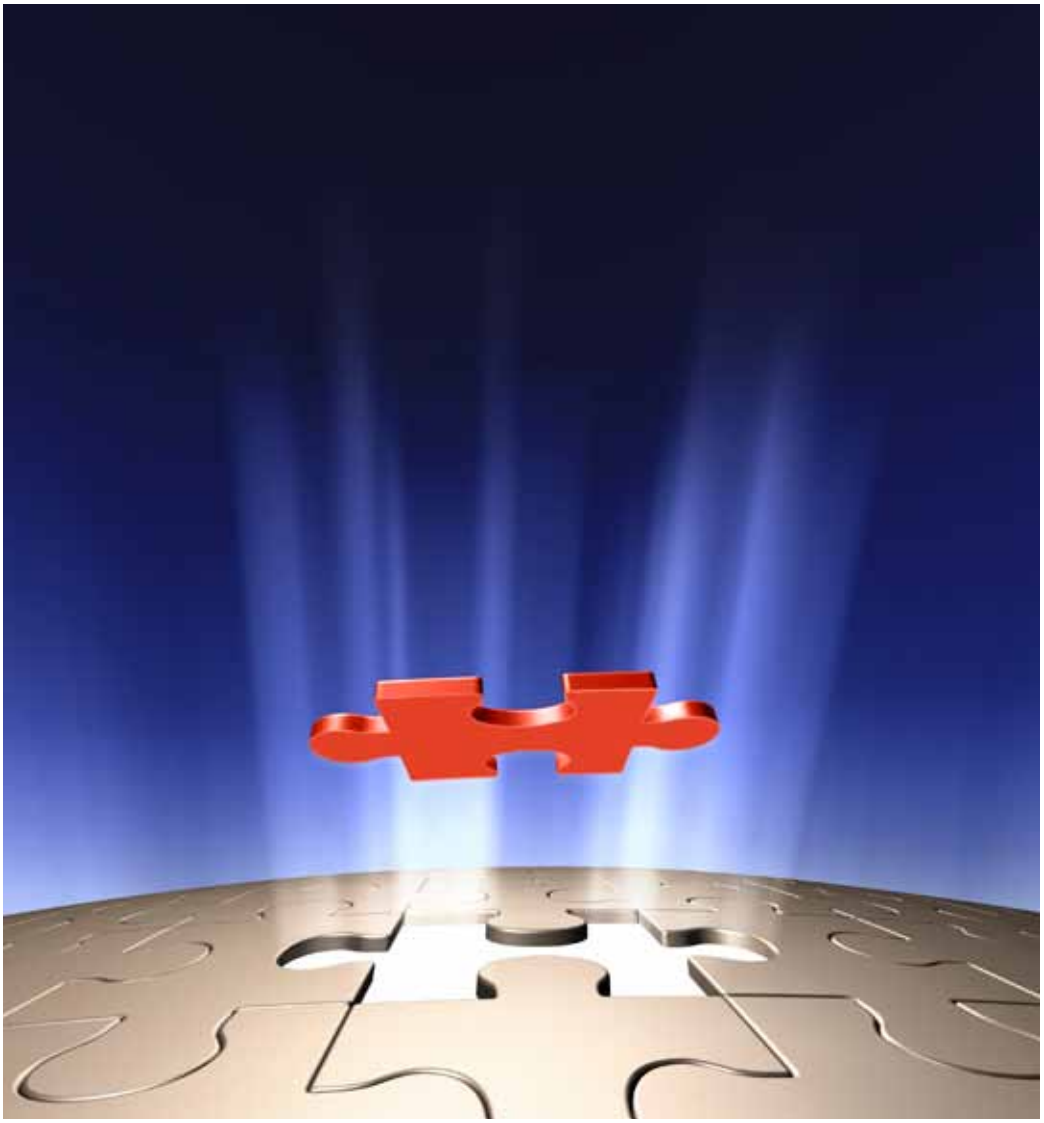

FIRST EDITION

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Foreword: a golden chain

If you are a doctor, it is because other doctors have taught you what they know. There is a golden chain of learning that extends back into the past and will extend into the future, each generation building a culture that values learning at the heart of clinical practice. Like all chains, this one is only as good as its weakest link.

The traditional methods of training are under pressure in hospitals today, with increasing specialisation of practice and increasing demands for clinical productivity. Waiting patients and performance targets leave consultants and senior registrars time-poor. Simultaneously providing excellent clinical care and delivering the highest standard of supervision and training of junior medical staff is a major challenge. Effective supervision at the point of care is vital for patient safety. Integrating effective training with this supervision is essential to ensure patient safety for the future.

If you are new to the supervisor role, we hope this book gives you a framework to underpin your practice. If you are a seasoned supervisor, we hope you find some new insights here. We can all become more effective teachers with support, reflection and feedback.

We hope this book will help make the sometimes daunting task of clinical supervision seem a little more achievable.

Simon Willcock
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Contents

The supersummary guide to supervising doctors in training

Key messages

- Contributing to the professional development of junior doctors can be one of the most rewarding parts of a senior clinician's job.
- The quality of supervision makes a difference to the quality of patient care.
- Supervision of junior doctors can be delegated but never abdicated.
- It is not sufficient to wait for the trainee to seek assistance. The supervisor must be actively engaged in identifying the trainee's current level of ability and function, and must anticipate potential problems and be proactive in finding solutions.
- Good supervision turns the necessity for clinical oversight into the opportunity for clinical teaching.
- Good clinical teaching by supervisors takes time, but saves time by reducing errors and creating more competent and independently capable trainees.
- Good supervision keeps the trainee safe and well by actively monitoring the trainee's level of stress and ability to cope.

Patient safety comes first

The safety of the patient is the responsibility of the admitting medical officer (AMO). This is not a responsibility that can be delegated away. The AMO is responsible for supervising the work of junior doctors caring for their patients. This means (at a minimum) that the AMO:

- discusses the management plan for the patient with doctors acting under the AMO's instructions to ensure their understanding
- routinely oversees patient care to ensure that junior doctors are acting competently
- is vigilant to detect triggers for further involvement (to prevent or correct management errors by junior staff, to escalate care)
- is accessible when junior doctors call for help.

Objectives of supervision

- Good patient care and treatment
- Junior clinician learning
- Junior clinician welfare (including reduced stress)
- Clinical team building

Active supervision

Supervision is passive when the supervisor's role in patient care relies on routine ward rounds, and the trainee, working mostly without direct supervision, is expected to identify any need for additional advice or assistance.

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support trainees when they need help, whether or not a request for help is made. Active supervision acknowledges that some trainees, or all trainees in some situations, are "unconsciously incompetent" — that is, *they do not know what they do not know*, and will not always recognise situations that are beyond their current abilities where patient safety may be at risk. ▶ p8.

The A-rated clinical supervisor

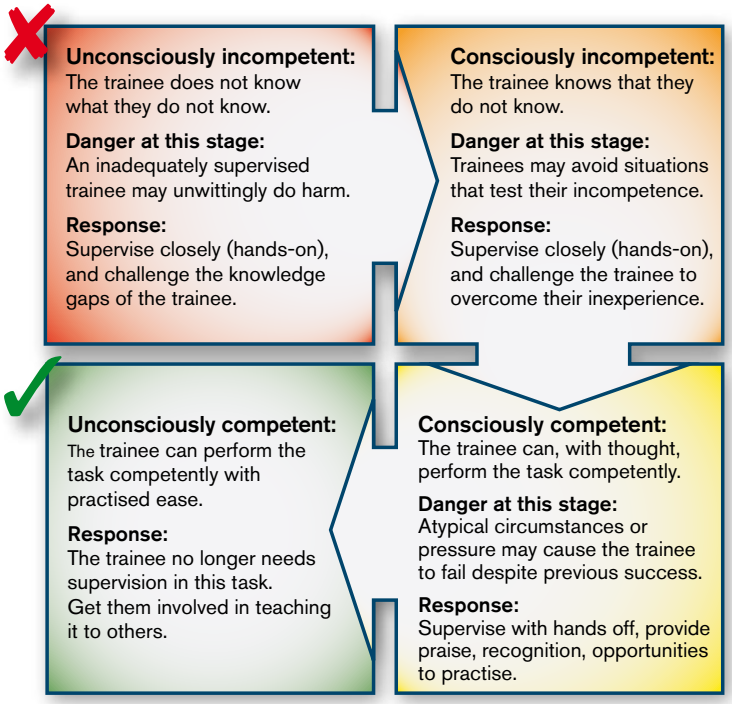
- Available
- Approachable
- Able (as both clinician and teacher)
- Active (finds the gaps)

What makes a good supervisor? ▶ p11.

Hands-on, hands-off: An effective supervisor knows when to give trainees direction, and when to give them freedom of action. Both hands-on and hands-off supervision are active processes, requiring the exercise of judgment. ▶ p14.

What makes good clinical teaching

- Collaboration and active involvement: adults like to have input into their learning.
- Relevance: to the current clinical duties and future career plans of the trainee.
- Appropriateness to the level of the trainee.



- Socratic method: asking and encouraging thinking.
- Setting clear goals: so that trainees know what learning outcomes are expected. Clear goals are SMART: Specific; Measurable; Attainable; Realistic and Timely.
- Giving feedback: so that trainees know how they are going.
- Seeking feedback: so that you know how effective your teaching has been.

Ten top tips for teaching ▶ p18.

Bedside teaching is the place where theoretical knowledge is made practical with real patients. Bedside teaching is enjoyed by most patients and considered by trainees to be the most effective way to learn clinical skills. **▶ p20.**

Rounds (▶ p22): consultants should aim to achieve the following in their ward-based teaching:

- Adequate communication of a management plan, with opportunities for clarification (including questions) by junior medical staff.
- A teaching point to be illustrated at each ward round.
- Observe at least one short case study per term with each trainee.
- Collaborate with other staff members to assess the clinical, communication and professional skills of trainees and provide them with informal appraisals.

Feedback on how they are doing is one of the most important things that trainees receive from their supervisors. **▶ p28.**

Teaching procedural skills (▶ p23):

1. Demonstration: Trainer demonstrates at normal speed, without commentary.
2. Deconstruction: Trainer demonstrates while describing steps.
3. Comprehension: Trainer demonstrates while trainee describes steps.
4. Performance: Trainee demonstrates and describes steps.

Tips for giving lectures ▶ p29.

JMO handover

Senior leadership should be present to decide who and what should be handed over. Senior staff supervision of handover improves patient care, builds the skills of junior medical staff and reduces the need to call consultants back. **▶ p25.**

The registrar as supervisor

JMOs appreciate registrars as hands-on supervisors and effective clinical teachers. Developing supervisory skills is an important part of registrar training. Delegate supervisory responsibilities to registrars, assess their performance and provide training and feedback.

Because of their closer experience, registrars will often have more insight into the skills, mental state and progress of your prevocational trainees than you do. Seek their opinion as part of assessing your trainees (but do not substitute their opinion for an exercise of your own judgement). The ultimate responsibility for assessing trainees and managing their welfare remains with the term supervisor. **▶ p32.**

Being a term supervisor: ▶ pp34–52.

See the contents list for more detail: **▶ p1.**

About this book

CETI has produced this book in response to the request from many involved in training junior doctors for a simple and practical guide to clinical supervision.

We hope this handbook will help registrars and senior medical staff supervise prevocational trainees (junior medical officers).

It provides information about:

- supervising junior doctors in ways that contribute to the safety and better medical care of patients
- effective methods of contributing to the education, welfare and professional development of junior doctors
- implementing the Australian Curriculum Framework for Junior Doctors
- assessing and certifying the competence of junior doctors.

This handbook is not a policy document. It gives tips and suggestions based on the published evidence of what makes good supervision and the knowledge of many experienced supervisors and directors of training in New South Wales.

For further information about NSW Department of Health policies on supervision, see the NSW Health website: <www.health.nsw.gov.au>.

Website

This handbook, updates and other useful resources are available on the website of the Clinical Education and Training Institute:

www.ceti.nsw.gov.au

Follow the link to Prevocational Training.

Introduction: the purpose of supervision

For this "superguide", we have identified **clinical supervision** as having three key elements:

1. **Clinical oversight** to lead, guide and support the trainee at the point of care to ensure patient safety.
2. **Clinical teaching** to enable trainees to develop the competence and knowledge required for responsible practice.
3. **Trainee management** to ensure that trainees are safe and well in their work.

The responsibility for clinical supervision is the same whether at the patient's bedside, on a conference ward round, or on the telephone to the junior clinician.

- **Responsibility for supervision can be delegated, but never abdicated.**

There is evidence that good supervision reduces errors and improves patient care,[1] and that inadequate supervision is a contributing factor in critical incidents with poor patient outcomes.[2] Hore et al suggest that unsupervised experience may lead registrars and other junior staff to accept lower standards of care.[3] It is far better for supervising doctors to be actively engaged in supervision that prevents errors and maintains standards than to be attempting to manage problems after the event.

Successful supervision uses the necessities of clinical oversight as the opportunity for training and education, so that safe supervision today becomes the foundation of safe independent practice by the trainee in the future.

The importance of active clinical supervision cannot be underestimated, yet many supervisors feel that they do not always have the time or the skills to provide it.

This book is focused on practical advice to improve the effectiveness and educational value of clinical supervision.

Objectives of supervision

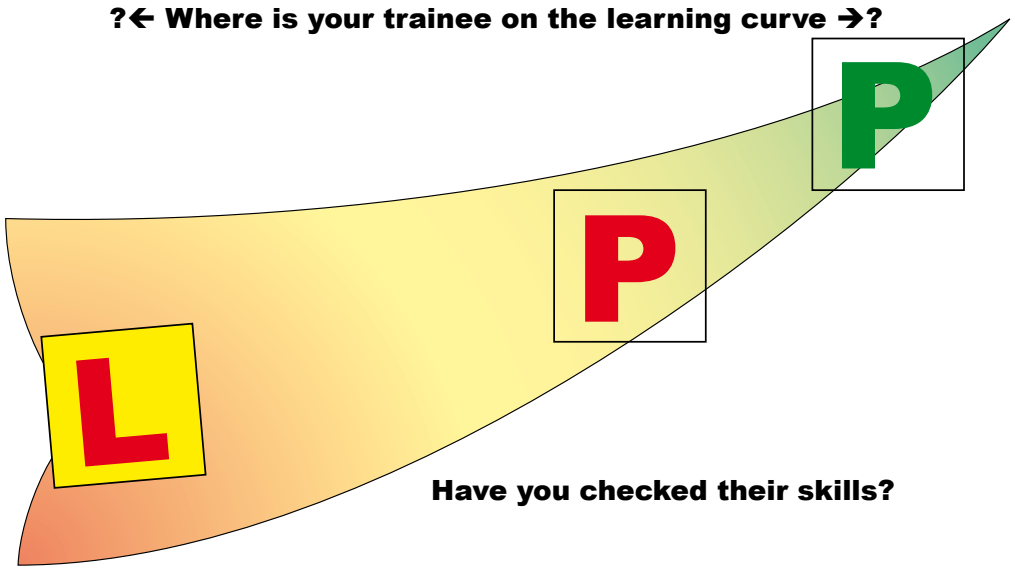
- Good patient care and treatment
- Junior clinician learning
- Junior clinician welfare (including reduced stress)
- Clinical team building

Part one

Clinical oversight

- The responsibility for clinical supervision is the same whether at the patient's bedside, on a conference ward round, or on the telephone to the junior clinician.

1 Patient safety comes first



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- discusses the management plan for the patient with doctors acting under the AMO's instructions to ensure their understanding
- routinely oversees patient care to ensure that junior doctors are acting competently
- is vigilant to detect triggers for further involvement (to prevent or correct management errors by junior staff, to escalate care)
- is accessible when junior doctors call for help.

The practical operation of hospitals means that patient care will be handed over from team to team (eg, from day to night, or weekday to weekend). The AMO may not be present at all of these handovers, but must ensure that the handover conveys all the information essential to the safe care of the patient.

2 Active supervision

Supervision is passive when the supervisor's role in patient care relies on routine ward rounds, and the trainee, working mostly without direct supervision, is expected to identify any need for additional advice or assistance.

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support trainees when they need help, whether or not a request for help is made. Active supervision acknowledges that some trainees, or all trainees in some situations, are "unconsciously incompetent" — that is, *they do not know what they do not know*, and will not always recognise situations that are beyond their current abilities where patient safety may be at risk. (See "Knowing where you're at".)

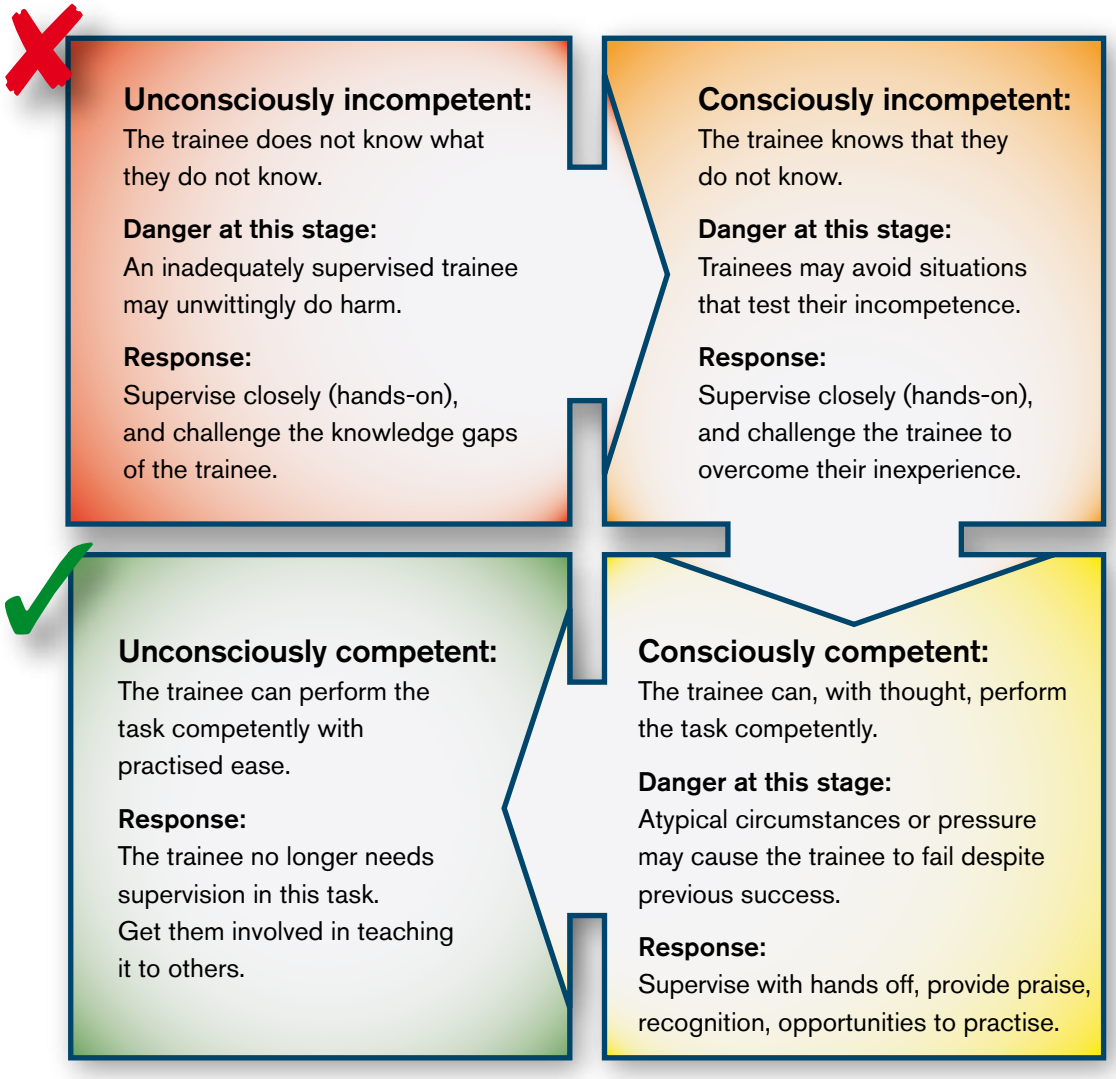
Active supervision requires the supervisor continually to seek clues or evidence that more direct oversight is needed or that direct patient care by the supervisor is required. A study in the United States found that when clinician supervisors saw the patient themselves rather than relying on trainee reports, they judged the patient to be more seriously ill.[4] This finding will resonate with the experience of many supervisors.

The elements of active supervision have been described[5] as:

- **Routine oversight**, which must be sufficiently vigilant to pick up clues that the supervisor's direct intervention in patient care is needed.
- **Responsive oversight**, when the supervisor actively seeks evidence of trainee performance and responds with more a "hands-on" or "hands-off" approach to supervision (for more on this, see page 14).
- **Direct oversight**, when the supervisor directly intervenes in patient care, as when the senior clinician is clearly responsible for taking the immediate action required.
- **Backstage oversight**, when the supervisor ensures that care is progressing appropriately by checking the trainee's record keeping, reviewing tests and imaging, and talking with other members of the clinical team. Backstage oversight also includes the management of systems to safeguard care, such as handover routines and protocols for escalating care.

3 Knowing where you're at

In the learning cycle described by Peyton,[6] trainees move through four stages in the acquisition of particular competencies, from unconsciously incompetent to unconsciously competent.



(Figure adapted from Peyton.[6])

4 The supervision layer cake

The base layer: Continuous routine, responsive and backstage oversight of the trainee's activity, with direct patient care by the supervisor as the need arises.

The soft centre: Communications to build understanding. The supervisor learns what the trainee needs to know. The trainee learns what the supervisor has to teach. They build a professional relationship based on respect and collaboration. The relationship between the trainee and the supervisor has been identified as a key element in the continuing educational development of the trainee.[1,7] Many supervisors find that this relationship becomes one of the personally satisfying and rewarding parts of their career.

The upper layer: Ongoing educational supervision expressed in clinical teaching, feedback, assessment, and planned activities for professional development.

The icing on the cake: Safe patient care, now and for the future.

This is the recipe for effective supervision: the supervisor must combine active clinical oversight with clinical teaching, feedback, assessment and planned activities for professional development.

It is not a matter of time spent, but how a supervisor approaches the task that makes the difference. We can all identify supervisors who are excellent clinicians and very busy, yet who provide routine and responsive oversight for their trainees, anticipate the clinical risks where trainees lack understanding or experience, and support their trainees to become more effective and independent.

What makes a happy trainee?[6]

- Being supported, especially out of hours
- Being given responsibility for patient care
- Good teamwork
- Receiving feedback
- Having a supportive learning environment
- Being stimulated to learn
- Having a supervisor take a personal interest

The A-rated teachable trainee

- Attitude (not arrogant, anxious, or overawed)
- Aptitude (has baseline of clinical skills, communication skills and knowledge)
- Attuned (focused on learning and not bored or perfunctory)

5 What makes a good supervisor?

Supervisory skills

Being available: This is the big one: trainees feel lost when they encounter a clinical situation beyond their current ability and they cannot get advice from their supervisor.

Being in charge: Supervisors should know what is going on under their watch and should give clear and reasonable directions to trainees. Trainees should know what is expected of them at all times.

Being vigilant: Supervisors should know what is going on with patients under their care, and be ready to respond personally if necessary. Supervisors should know their trainees, and should know what level of supervision is necessary for safe practice. They anticipate red flags and actively find the gaps in trainee performance.

Being organised: To make the most of the limited time available.

The A-rated clinical supervisor

- Available
- Approachable
- Able (as both clinician and teacher)
- Active (finds the gaps)

Personal skills

Empathy: Do you remember what it was like to be a trainee? A good supervisor uses insight and understanding to support the trainee.

Respect: Showing respect for trainees and others, regardless of their differences from yourself, engenders respect.

A direct manner and honesty in communications: A common problem for trainees is uncertainty about what their supervisor thinks or wants. Honest feedback from supervisors is highly valued.

Confidentiality: Trainees are more open and honest about errors or lack of competence if they can discuss these matters in confidence with their supervisor.

A motivating and positive attitude: Most people respond more to encouragement than to criticism, and criticism is more effective is if framed in constructive terms ("You are doing this well and will do even better when you ...")

Willingness to allow the trainee to grow, be independent and make some mistakes.

Clinical skills

Contrary to the old saying, in medicine, those who cannot do, cannot teach. The modelling of good clinical skills is one of the chief ways that supervisors help their trainees.

The clinical skills of supervisors should be up-to-date and evidence-based.

Teaching skills

Demonstrating clinical skills: providing hands-on care for patients in the presence of trainees — and discussing what is being done.

Linking theory and practice: that is, not only demonstrating skills but explaining the logic and the evidence behind the practice.

Providing opportunities to practice skills: making time and space available for the trainee to be hands-on, breaking procedures into steps, providing direction, sharing care.

Collaborative problem solving: giving trainees a clinical problem and working with them towards a solution.

Socratic method: asking questions to discover the state of the trainee's knowledge and to encourage independent thinking and problem-solving is a key method of effective medical teaching. Effective questioning reveals what it is that really needs to be taught, uncovers misunderstandings, and reinforces and extends existing knowledge. Questions keep trainees engaged, "on their toes", listening and thinking. One proviso: don't use questions to "prosecute" or humiliate the trainee, or to show off your own expansive knowledge.

Individualising learning: is only possible if you begin by asking questions. Teaching is more effective if it is tailored to the trainee's interests, ambitions and current level of knowledge and ability.

Giving feedback: that is timely, specific, constructive and given in an appropriate environment. Good givers of feedback also invite feedback from the trainee, with a view to improving their teaching technique.

Providing appropriate learning resources: knowing what is available to help trainees and selecting material pitched at the appropriate level.

What makes a poor supervisor?

Absence: supervision that is remote or infrequent is dangerous and ineffective.

Rigidity: setting rules without giving reasons, giving orders without explanations. This is not to say that supervisors have to explain everything all the time — but there has to be a time for explanations. The justification for systems is one of the things trainees must learn.

Intolerance and irritability: leads trainees to avoidance (hiding errors and gaps in their competence).

Not teaching.

A negative or relentlessly critical attitude: especially publicly criticising the trainee's performance or seeking to humilate the trainee.

Treating trainees as clerks: trainees can benefit from doing the paperwork, but not if that's all they do. Opportunities for hands-on clinical care and meaningful interactions with patients and the clinical team are essential.

Writing off trainees in difficulty: there are many reasons for suboptimal performance, including poor orientation or poor supervision, which can be addressed with simple measures.

6 A matter of time

Many consultants report that they simply do not have the time to actively supervise trainees in the way that they would like. This is a real problem with no easy solutions.

However, time spent actively supervising trainees is rewarded in two ways. The first is that active supervision improves trainee performance, which saves time and trouble in patient care. The second is that supervisors who increase their involvement with trainees tend to report higher levels of job satisfaction, as playing a leading role in the development of junior doctors is personally rewarding. It builds better team interactions and contributes to self esteem for all involved.

Even small changes in how supervisors organise their clinical duties can make big differences to the effectiveness of supervision.

Tips for time management

"Budget" rounds: For a busy ward round on which you will have registrars, prevocational trainees and students, consider en route which patients should be the subject of short teaching points relevant to each level of trainee. For example:

- For the student: a clinical sign to elicit.
- For the prevocational trainee: a prescribing question that explores knowledge of physiology and pharmacology, or a test to be interpreted.
- For the registrar: questions about the evidence base behind a treatment decision.

One minute teaching moments: Develop mini-tutorials on key topics that break complex issues into simpler teachable parcels.

Recycle: Having developed a stock of teaching points and mini-tutorials, the supervisor can recycle them each term: they will still be fresh to the trainees.

Delegate and double the learning: Ask the registrar to design a series of questions about a patient to teach the prevocational trainee clinical reasoning on a particular issue. Or ask the prevocational trainee to be "registrar for a day" and present a case.

Share: Use staff meetings to share ideas for mini-tutorials and teaching points, and create a bank of prepared teaching for all supervisors to use.

7 A key concept: hands-on, hands-off

An effective supervisor knows when to give trainees direction, and when to give them freedom of action. To move the trainee from consciously incompetent to consciously competent, the supervisor must actively calibrate the level of support provided.

Studies[3,8] suggest that junior doctors value supervisory support of two kinds:

- "Hands-on" supervision — interactions with clinicians who are expert in areas where they need help
- "Hands-off"supervision — being trusted to act independently, being given space to deploy their nascent skills and test their growing clinical abilities.

Trainees also value an intermediate zone that allows them to shift back and forth between monitored (hands-on) and independent (hands-off) practice.

"Hands-on" supervision

Positive examples:

- Guidance on procedures, skills training sessions
- Seeing patients with consultant
- Discussing mistakes
- Opportunities to discuss patient management

Negative examples:

- Feeling intimidated, humiliated and watched
- Feeling disempowered

"Hands-off" supervision

Positive examples:

- Identifying crucial supervision moments
- Having enough room for developing independence
- Feeling trusted
- Opportunities for de-briefing

Negative examples:

- Being left alone to deal with challenging situations
- Feeling abandoned – unable to contact senior staff
- Needs for de-briefing not met

From a supervisor's point of view, both hands-on and hands-off supervision are active processes, requiring the exercise of judgment. How far along the trajectory of development is the trainee? When is it time to intervene? Hands-off supervision is not absence of supervision.

In general, trainees need more hands-on supervision at the beginning of training and increasing amounts of hands-off supervision as they progress.

8 Case study: clinical supervision

Scenario

A consultant surgeon does a ward round of 30 patients with his registrar, an advanced trainee and a new intern. The consultant has heavily booked rooms for which he is already late, and Outpatients is ringing the registrar as there is a busy clinic requiring his presence.

One patient is noted to be uncooperative with mobilising post-procedure as she is too dizzy and weak to attempt standing.

What next?

Path one

The consultant, preferring the prompt responses of the advanced trainee, barely looks at or speaks to the intern, and does not realise that she is new. He delegates to the registrar to "sort it out" and leaves.

The registrar advises the intern to get a cardiology consult and goes to the clinic without leaving contact details or a follow-up arrangement.

The cardiology registrar informs the intern that she needs to get a CXR and ECG and they will review the patient tomorrow or the next day.

The next day the patient has a severe bradycardic episode and is moved to ICU. The consultant complains about the intern in front of nursing staff and the patient's family.

Path two

The consultant, knowing that the intern is new, asks her to get the charts and together they examine the vital signs, the most recent lab results and the medication chart.

Through brief questions he has the intern establish that the patient's blood pressure is lowish, with postural hypotension, slow pulse rate and rising creatinine and potassium. Antihypertensives, ACE inhibitor and NSAIDs are ceased. This reveals the need for prompt action: to repeat the potassium level, give IV fluids, secure an ECG and further monitoring, and get an urgent renal consult.

The consultant departs after requesting to be informed of progress in two hours. The intern is overwhelmed by work and forgets to call, but the consultant rings to check and calls the renal physician himself.

The patient is managed in the ward without a crisis.

Path one exemplifies bad supervision: the consultant abdicates rather than delegates responsibility; he assumes a level of knowledge and experience that the intern does not yet possess (he is hands-off when he should be hands-on); and, instead of support, he blames the intern in circumstances that are humiliating. For some trainees, this kind of experience can be a career-breaker.

Path two exemplifies good supervision: the consultant is an active, not passive, supervisor; he identifies and addresses the unconscious incompetence of the intern; teaches by checking level of understanding and building from there through logical questioning; ensures that responsibility is clearly delegated and follows up to check. *Patient safety is assured now and made more likely for the rest of the trainee's career.*

Part two:
Clinical teaching

> "Good teaching is nothing to do with making things hard. It is nothing to do with frightening students. It is everything to do with benevolence and humility; it always tries to help students feel that a subject can be mastered; it encourages them to try things out for themselves and succeed at something quickly."
>
> — Ramsden P. Learning to teach in higher education. London: Routledge, 1992.

9 What makes good clinical teaching?

Collaboration and active involvement: adults like to have input into their learning.

Relevance: to the clinical duties currently required of the trainee, or (even better) to the future career plans of the trainee.

Teach the individual: ascertain what the trainee is interested in and then direct your teaching to this motivation. For example: one may teach lumbar puncture differently to a future anaesthetist than to a future psychiatrist. The first is more interested in performing the procedure and will need comprehensive knowledge; the second may focus on when the procedure may be required diagnostically and the risk involved.

Appropriateness to the level of the trainee.

Socratic method: asking and encouraging thinking.

A failure of some didactic teaching (lecturing) is that time is spent teaching trainees things they already know. Didactic teaching is most effective when you know the knowledge base of your audience (ask first).

The advantage of the Socratic method is that is reveals what trainees do know and invites them to extend their knowledge. But: don't turn questioning into a grilling.

Setting clear goals: so that trainees know what learning outcomes are expected.
Clear goals are SMART: Specific; Measurable; Attainable; Realistic and Timely.

Giving feedback: so that trainees know how they are going.

Seeking feedback: so that you know how effective your teaching has been.

Simply telling people what you expect them to learn will focus their attention in a clinical encounter.

Feedback given and received lets everyone know whether the intended outcomes are being achieved.

Adult learning is a collaboration between teacher and student.

10 Ten top tips for teaching

1. **Every little bit helps.** Even if you don't have the whole package worked out, it's still worthwhile sharing what you can, as best you can. Don't have time to run through a procedure in full? Draw the trainee's attention to one key aspect of technique. No time for a complete debrief after a critical incident? Ask a few key questions to check trainee understanding of what occurred and give quick feedback. **Seize the teaching moment.**
2. **Develop teaching "pearls".** Pearls are two-minute scripts that teach key lessons relevant to your clinical practice. You need to practice these lessons to make them as short and clear as possible — then you can use them again and again.
3. **Use the Socratic method.** Ask questions to discover the state of the trainee's knowledge and to encourage independent thinking and problem-solving. Questions keep trainees engaged, "on their toes", thinking and listening. One proviso: don't use questions to "prosecute" or humiliate the trainee, or to show off your own expansive knowledge.
4. **Invite trainees to set the agenda.** It is a basic principle of adult learning that the student should be involved in decisions about the direction and content of learning. Your ultimate objective as a supervisor is to foster the trainee's ability for self-directed lifelong learning.
5. **Encourage questions.** Trainee questions should always be treated with respect. You may be shocked that they did not already know, but on closer inspection, may discover that others are just keeping quiet. The three most important words in teaching and learning are "I don't know".
6. **Focus the learner.** Start any teaching by setting up the importance of the lesson. Teaching is more effective if it is tailored to the trainee's interests, ambitions and current level of knowledge and ability. Answer the question: why should trainees pay attention to what you are about to teach?
7. **Focus the lesson.** Don't try to teach too much at once. Try not to repeat what the trainee already knows. Clinical situations are complex, but limit the lesson to the key aspects that are at the leading edge of the trainee's knowledge. Procedures can be broken down into steps, not all of which have to be covered in one lesson.
8. **Demand independent learning.** Don't try to teach everything — give enough information to set trainees on track, then ask them to complete the picture themselves. Set tasks that require trainees to act on the information you have provided. Keep learning open-ended.
9. **Teach evidence-based medicine.** Build a lifelong learning attitude in your trainees. Even more important than knowing the current best answer to a clinical problem is having the skills to identify a clinical question, search the medical literature, appraise the evidence and form an evidence-based plan.
10. **Evaluate your own practice as a teacher.** How well did your trainees learn the lesson you intended? Every time you teach you have a chance to learn how to do it better (and more easily) next time. Try different methods and compare trainee outcomes. Seek feedback from your trainees. Compare notes with your peers.

11 Learn to teach

Clinical teaching is a skill that must be learned like everything else in medicine.

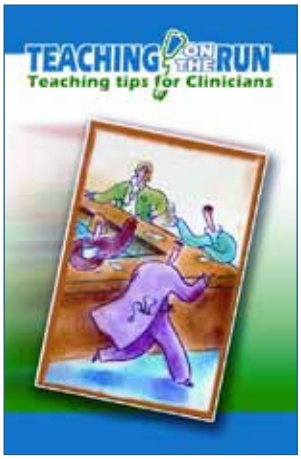
If you haven't done it already, look for an opportunity to do the *Teaching on the run* training course, developed by Professor Fiona Lake and colleagues at the University of Western Australia.

Workshops are designed for 12–16 participants and run for 2–3 hours. Each workshop uses a variety of small group teaching techniques including discussion, video presentation, small group work and reflection.

The workshops are:

1. Clinical (bedside) teaching
2. Skills teaching
3. Feedback and assessment
4. Supporting trainees
5. Planning term learning
6. Effective group teaching

Look on the CETI website for information about *Teaching on the run* workshops and contacts in New South Wales.



Teaching on the run: teaching tips for clinicians[9] is an excellent pocket book full of distilled practical advice from the workshops. It can be purchased online from the eMJA Shop <http://shop.mja.com.au>, or from the University of Western Australia <http://msc.uwa.edu.au/meddent/totr>.

The articles that make up the book can also be viewed online for free at <www.mja.com.au> or <http://www.meddent.uwa.edu.au/teaching/on-the-run/tips>.

For those of you who are really on the run, the following pages contain a super-short guide to clinical teaching for supervisors.

12 Bedside teaching

Bedside teaching is at the heart of effective clinical training: it is the place where theoretical knowledge is made practical in the real world, with real patients. Research at the University of Newcastle and John Hunter Hospital suggests that bedside teaching is enjoyed by most patients and considered by trainees to be the most effective way to learn clinical skills.[10]

Tips for bedside teaching[10-12]

Patient comfort issues

- If possible, provide advance notice of visit.
- Limit length of time for patient comfort.
- All procedures, discussions and communications should be explained and understandable to the patient.
- Avoid or modify presentations at the bedside.
- Visit the patient after rounds to give thanks and answer questions.

Teaching

- Start small, and stay within your comfort zone as a teacher.
- Use the patients you have: what's old to you is new to the trainee.
- Budget time for bedside teaching, but use a visit you would have been making anyway.
- If time is short: demonstrate, make a key point to the trainee, ask a key question, move on.

If time is available:

- Orient the trainee to your plans for the session. Negotiate the goals. Tell the trainee what is to be taught.
- Involve trainees: let them select patients or the focus of teaching; ask them to perform all or part of the interview, examination or procedure, or get them to demonstrate the abnormal finding.
- The Socratic method is generally better than just telling, because it allows you to assess the trainee's knowledge and motivation.
- If explaining, ask for report back to check understanding. If directing: ask the trainee "Why am I asking you to do this?"
- Ask trainee to elicit part of the history — see if they are on track to finding the right diagnosis.
- If trainee is off track, make a smooth transition to take over the clinical interaction.
- Don't criticise trainees at the bedside. Debrief elsewhere.
- Afterwards: seek feedback. Reflect on the effectiveness of the session and prepare for next time.

13 Examples of bedside teaching

Case 1

A supervisor and an intern are doing a ward round of patients admitted under their care during the preceding night.

At the bedside the intern presents Mr J, an obese 69-year-old man who has been admitted with a provisional diagnosis of ureteric colic and is awaiting a CT KUB study.

The patient is described as stable, with normal electrolytes and creatinine.

The supervisor enquires as to what features in the history led to the provisional diagnosis and the intern describes the patient as having awoken from sleep with severe left-sided abdominal pain from renal angle to the groin. His distress had settled significantly after IV morphine.

The supervisor then asks about the symptoms associated with the pain that are typical of hollow organ colic. He encourages the intern to make fresh inquiries of the patient at the bedside, where it becomes clear that rather than being restless with the pain, he feels the need to lie very still, and was initially very faint, although this has settled.

Leading the intern to check current vital signs, the supervisor then asks the intern if other differential diagnoses were important to exclude and how promptly this could be determined. The intern then recognises the possibility of a ruptured aortic aneurysm and together the supervisor and intern initiate the immediate actions required.

Case 2

A respiratory physician and an RMO are at the bedside of a 45-year-old woman admitted with breathlessness. The RMO is keen to complete his paperwork, but the supervisor asks the RMO to demonstrate the abnormal signs in the respiratory system.

As a budding obstetrician, the RMO jokes that this is not something he will need to do often. The physician reminds him that nearly all his third trimester patients will complain of breathlessness, and the RMO responds with more focused interest. The patient understands that this interaction is based on her case, but that some of it is theoretical teaching and she should not be concerned.

A brief review of the resident's technique reveals that he is leaving no time for auscultation in exhalation. This is corrected. The causes of a "clear" chest with a large A:a gradient and the best investigation for breathlessness for both pregnant and non-pregnant patients is discussed.

14 Rounds

Ward rounds are an opportunity for junior doctors to learn and improve their skills, not only in patient care, but also in teamwork and communication. They are where important decisions are made in patient care and where management plans are formulated.

They are invaluable opportunities for supervisors to teach junior doctors in a practical setting with patient and multidisciplinary team involvement.

As a minimum, consultants should aim to achieve the following in their ward-based teaching:

- Adequate communication of a management plan, with opportunities for clarification (including questions) by junior medical staff.
- A teaching point to be illustrated at each ward round. Even five minutes of teaching on each ward round will make a difference to trainee performance.
- Observe at least one short case study per term with each trainee.
- Collaborate with other staff members to assess the clinical, communication and professional skills of trainees and provide them with informal appraisals.

Tips for teaching during rounds

See also "Tips for bedside teaching" on page 20.

- Ensure that all team members are actively engaged in the process.
- Make learning an explicit objective of ward rounds and make the specific learning outcomes of each round explicit ("So, what is the lesson of this case?").
- Build the team through discussion and delegation of responsibility. Give different team members a chance to lead discussion or present a case. Prevocational trainees enjoy an opportunity to be "registrar for a day".
- A recent study found that more time was devoted to patients discussed earlier in the round, regardless of diagnosis, and recommended that the order of patient discussion should be planned to highlight specific teaching points.[13]

McLeod's guidelines for effective ward rounds:[14]

- Planning: brief trainees on the purpose of rounds and seek information about trainee expectations and abilities.
- Timing: select patients for discussion.
- Preparation: do background reading for selected cases.
- Patients: good learning occurs with patients who can give a reliable history, present with atypical manifestations of common disease, exemplify pathophysiology, or present challenges to the instructor's level of expertise.
- Location: bedside for the experience of an actual patient.
- Format: a mixture of problem-oriented (case presentation leading to management plan), basic-science (signs and symptoms considered from anatomic and pathophysiological perspectives), clinical skills (history-taking, physical examination).
- Emphasis: problem-solving rather than fact-accumulating.
- Trainee participation: usually have the junior member of the team present the case, but sometimes use a senior to save time and to provide a role model.
- Assessment and feedback: is for everybody on the team. Questions must be encouraged.

15 Teaching procedural skills

The Australian Curriculum Framework for Junior Doctors includes a long list of skills and procedures that prevocational trainees need to learn for the safe treatment of patients.

Skills training can begin with virtual experience: texts, videos, online tutorials, simulations, but it has to be completed in the workplace with real patients. Supervisors need to be ready to teach a skill when the opportunity arises.

A four-step approach to teaching skills described by Walker and Peyton[15] and adopted in *Teaching on the run*,[9] is:

1. **Demonstration:** Trainer demonstrates at normal speed, without commentary.
2. **Deconstruction:** Trainer demonstrates while describing steps.
3. **Comprehension:** Trainer demonstrates while trainee describes steps.
4. **Performance:** Trainee demonstrates and describes steps.

Tips for skills teaching

- Call for focus: set the scene; motivate (importance to trainee, to patient, to system).
- Don't forget fundamentals: hygiene and aseptic technique; patient communication and consent.
- Demonstration: Make sure the trainee can see. If possible, invite questions afterwards.
- Particularly for more complex procedures, not every step needs to be taught in every lesson. Begin by establishing what the trainee already knows. Review unknown steps in more detail.
- Demonstration by the trainer can be combined with performance by the trainee.
- Repetition is the key to skills training, with the focus of the lesson moving forward each time.
- A simple scale for assessing trainee competence in a procedure:
  - 5 No errors observed
  - 4 Occasional errors, corrected by trainee
  - 3 Frequent errors, corrected by trainee
  - 2 Frequent errors, not corrected by trainee
  - 1 Trainee unable to proceed without step-by-step instruction.

ACFJD skills and procedures

GENERAL

Measurement
Blood pressure
Pulse oximetry

Interpretation of results
Pathology
Radiology
Nuclear medicine

Intravenous
Venepuncture
Intravenous cannulation
Intravenous infusion set up
Intravenous drug administration
Intravenous fluid and electrolyte therapy

Diagnostic
Blood sugar testing
Blood culture
Wound swab

Respiratory
Oxygen therapy
Nebuliser/inhaler therapy
Bag and mask ventilation
LMA and ETT placement (ADV)

Therapeutics/Prophylaxis
Anticoagulant
Antibiotic
Insulin
Analgesia
Bronchodilators
Steroids

Injections
Intramuscular injections
Subcutaneous injections
Joint aspiration or injection (ADV)

WOMEN'S HEALTH
Palpation of the pregnant abdomen
Fetal heart sound detection
Urine pregnancy testing
Speculum examination
Diagnosis of pregnancy
Endocervical swab / PAP smear
Gynaecological pelvic examination

CHILD HEALTH
Infant respiratory distress assessment
Infant/child dehydration assessment
Apgar score estimation (ADV)
Newborn examination
Neonatal and paediatric resuscitation (ADV)

SURGICAL
Scrub, gown and glove
Assisting in the operating theatre
Surgical knots and simple wound suturing
Local anaesthesia
Simple skin lesion excision
Suture removal
Complex wound suturing (ADV)

EAR, NOSE and THROAT
Throat swab
Anterior rhinoscopy
Anterior nasal pack insertion
Auroscopy/otoscopy
External auditory canal irrigation
External auditory canal ear wick insertion (ADV)

16 Example of teaching procedural skills

Intern and registrar attend a patient who is having a short generalised seizure. The registrar applies bag valve mask ventilation with oxygen, demonstrating to the intern how to position the patient's airway for patency, and asks how the effectiveness of ventilation can be monitored and assessed, as well as what to do if the patient vomits. When the patient's condition has returned to regular respiration and oxygenation, the registrar disassembles another bag mask set up and then reassembles it step-by-step, demonstrating key aspects of the task to the intern.

The equipment is disassembled again and the intern talks through the set up, how to position the patient's airway and the need for ready access to suction. The intern takes over the application of the oxygen system and demonstrates the monitoring of adequacy of ventilation.

By this time the patient has regained her normal level of alertness.

Outcome: patient is better and intern is better at the procedure.

17 Teaching at handover

Well structured handover is an excellent learning experience that integrates communication, professionalism and clinical management. Trainees learn techniques of clinical description and case organisation in receiving a patient from others or preparing to handover a patient to others. Handover is also an important team-building exercise.

Clinical handover is the effective transfer of professional responsibility and accountability for a patient, or group of patients, to another person. Failures in handover have been identified as a major preventable cause of patient harm.[16] Junior doctors need to be encouraged to value handover and to see it as an essential and integral part of their daily work.

The Acute Care Taskforce's standard key principles for handover by Junior Medical Officers from shift-to-shift or team-to-team recommend senior leadership should be present at handover to decide who and what should be handed over.[17] Experience has shown that senior staff supervision of handover improves patient care, builds the skills of junior medical staff and reduces the need to call consultants back.

Tips for teaching at handover

- Supervisors can select particular patients at handover as the subject of bedside teaching (see page 20 for more on bedside teaching).
- Handover is an excellent opportunity for junior medical staff to take the lead in a teaching session. Ask trainees to select a case to present in more detail.
- Aim for one teaching point at each handover. A brief (not exhaustive) exploration of a key issue is of lasting value for the trainees involved.
- All trainees should be familiar with the ISBAR framework for communications at handover.

I	**Introduction** – Identify yourself, role, location and who you are talking to.	"I am (name and role), from (ward/facility) and I'm calling because (clear purpose)"
S	**Situation** – state the patient's diagnosis/reason for admission and the current problem.	"The situation is that I have a patient (age/gender), who is (diagnosis/deteriorating/stable). My concerns are (clear and succinct concerns). The current presenting symptoms are (clear, current and relevant symptoms and observations)."
B	**Background** – what is the clinical background or context?	By way of background (Give pertinent information which may include: Date of admission / presenting symptoms / medication / previous recent vital signs / test results / status changes and any relevant medical history)
A	**Assessment** – What do you think the problem(s) is? (Don't forget to have the current vital signs and a key problem list ready!)	"My assessment on the basis of the above is that the patient is….. they are at risk of ... and in need of ..."
R	**Recommendation** – What are you asking the person to do?	"My recommendation is that this patient needs (what test/action) by (who) within (timeframe)." Repeat to confirm what you have heard, eg, "I understand that I am to ... and you will …"

18 Other clinical teaching opportunities

Emergency team responses

When the crisis team attends a critical incident, it operates according to a strict protocol, and there is no time for explanations. It is important to review the event afterwards, or the trainee may remain in the dark about why things happened the way they did.

A few pertinent questions to reveal the trainee's understanding of the key issues are better than nothing when a full debrief is not possible. If time is short, at least you can point the trainee to sources of further information.

After-hours episodes

Most of the week occurs "after hours". Much of the trainee's experience is drawn from episodes of care provided "after hours". Supervision and training needs after hours are greater and require careful involvement of all senior clinicians at the point of care, at handovers and on the telephone to ensure active "find the gaps" supervision is provided.

After-hours ward calls are often a source of anxiety for the trainee, as the patients and their conditions are unfamiliar. The senior clinician must be alert to this unfamiliarity and provide a supportive environment while the trainee explains the situation. The supervisor must employ responsive oversight and be alert to every cue that the trainee may need direct supervision. This is often at the most inconvenient time for both the trainee and the supervisor, yet the power of reasoning a clinical problem together can enhance your patient's safety and the trainee's ability to manage independently in future.

The practice of each facility in alerting the AMO to a change in their patient's condition may vary slightly, but accountability for patient care is with the AMO. The follow-up of any unexpected change in condition remains the responsibility of the AMO. It is hazardous to assume that all is well if the trainee has not reported back on the result of planned interventions. On these after-hours shifts, the trainee may be distracted or overloaded with other patient problems, or may fail to recognise the red flag. Well documented instances of such occurences have been reported.[2]

Consultations

Advice from consultants and registrars from other specialist teams is often required for patient care. When a supervisor consults another team, the trainee should be included if possible because good communication skills are best acquired from role model opportunities. Delegating a consultation to a trainee without hands-on supervision is only appropriate in considered circumstances, but can be a key learning opportunity, as the trainee must distil the history, examination and progress, as well as frame the clinical question to be answered. Trainees often report being asked to arrange consultations without understanding why. Supervisors need to check that the trainee understands the purpose of the consultation and can communicate this to the consulting team. Ideally, the consulting team should record their reasoning and recommendations in responding to the request.

Phone

Many clinical consultations and episodes of supervision take place over the phone. Despite the distance, the supervisor's responsibility for patient safety is no less than when present at the point of care. There is a tendency to abbreviate phone calls to a minimum of information exchange, but the phone can be used to put the supervisor "virtually there" with the trainee during clinical encounters. Because the supervisor cannot see or touch the patient, there is an increased focus on the trainee's communication skills. Particularly in non-urgent contexts, the supervisor can work with the trainee to clarify the trainee's phone communication technique:

- Practise the ISBAR communication framework (see page 25).
- Provide feedback to the trainee on the trainee's selection and presentation of clinical information.
- Practise the "report-back" technique of confirming the content of a phone communication (repeat the essence of what you have been told and repeat the decisions for action that have been made) and require the trainee to do the same.

Telephone terrors

Fear of difficult conversations with consultants and registrars can discourage junior doctors from making a phone call at the time when it is most needed.

Supervisors need to support trainees use of the phone and develop their skills in presenting appropriate information.

19 Giving feedback

According to the JMO Forum, CETI's representative body of prevocational trainees, verbal feedback on how they are doing is one of the most important things that trainees hope to receive from their supervisors.

How to give effective feedback[9,18]

- **Be timely.** Give feedback as close as possible to the event. Don't wait until the end of term. However, pick a good moment for feedback (not when you or the trainee is exhausted, distracted or upset). Feedback on performance should be a frequent feature of your relationship with your trainees.
- **Be specific.** Vague or generalised praise or criticism is difficult to act upon. Be specific and the trainee will know what to do. Adopt a straightforward manner and be clear.
- **Be constructive.** Focus on the positive. Avoid dampening positive feedback by qualifying it with a negative statement ("I was very happy with your presentation, but ..."). For criticism, talk in terms of what can be improved, rather than what is wrong. Try to provide feedback in the form of solutions and advice. At the same time, if the trainee makes an error, feedback needs to be unambiguous ("You didn't use the correct technique for tying that knot. Next time ..."
- **Be in an appropriate setting.** Positive feedback can be effective when given in the presence of peers or patients. Negative feedback (constructive criticism) should be given in a private and undisturbed setting.
- **Use attentive listening.** Trainees should be given the chance to comment on the fairness of feedback and to provide explanations for their performance. A feedback session should be a dialogue.

Consequences of a lack of clear feedback to a trainee who is not performing adequately[18]

- Clinical care is not as good as it could be.
- Anxieties and inadequacies are not addressed. The trainee carrries these on to the next term.
- When weaknesses are exposed later, the trainee has difficulty accepting criticism because of previous "good reports".
- Others are blamed when the trainee is unsuccessful.
- Learning is inhibited, career progression is delayed.
- Other, more frank, supervisors may be devalued and attacked later.

20 Formal teaching

As a senior clinician, you are likely to be called upon to give lectures, and the one clear advantage is that your subject will probably match your expertise. Practice these tips to make your lectures effective:

- Consider your audience and shape your material to make it relevant to their current knowledge, current clinical responsibilities and objectives. If in doubt, consider using questions at the start of your lecture to establish where to pitch your talk.
- Think about lectures you have enjoyed or remembered and try to apply similar techniques.
- Don't read your lecture — most of all, don't read your Powerpoint slides. Talk to your audience.
- Stories, jokes and analogies are useful tools to make facts memorable.
- The first five minutes are vital: capture interest with a compelling start (why should the audience listen?), and explain what you intend to cover in your talk. If you have one key point above all, make it early.
- Respond to visual cues from the audience to change pace. Ask a question if you are not sure that the audience is with you.
- Vary your delivery and technique. Consider breaking the lecture with questions to or from the audience, or an activity to be carried out by the audience.
- Close your lecture strongly, with a summary of what you hope the audience will take away.
- Avoid overstuffing your lecture with material.

More tips

- A great guide is **Delivering a lecture** at http://teaching.berkeley.edu/bgd/delivering.html, from the book *Tools for Teaching.*[19]

Beyond the lecture

Don't forget the broad spectrum of teaching methods available to you as a teacher as alternatives or adjuncts to the lecture:

- simulations and role plays
- videos to demonstrate techniques or behaviours
- group discussions, case studies and problem-based learning
- computer-based education

These subjects go beyond what we can cover in this book — so explore. Even the simplest departures from the standard lecture format will make your lesson more memorable.

Part three

Trainee management

> "Supervision is a key component of working in a team. Supervision demonstrates a respect for supporting junior clinician learning and welfare and requires both supervisor and junior clinician to commit to supervision as an ethical and professional responsibility. Participation in supervision requires the supervisor and the junior clinician to be honest about performance and progress and to have the courage to raise problems when they occur."
>
> — Tay T, Sanger M, Llewellyn A.
> Best practice model for junior clinician supervision.
> Newcastle: HNEAHS, 2009.

21 Keeping trainees safe and well

The transition from university student to prevocational trainee can be stressful:

- Loss of structured learning environment coupled with increased demands on knowledge and performance
- Longer hours
- New responsibilities and confrontations with life and death experiences
- Unprecedented levels of administrative duties that may conflict with the trainee's self-image as a professional clinician
- Frequent changes in work environment, patients, team partners and bosses.

A national survey of JMOs in 2008 found that some JMOs had serious difficulty adjusting to their role, or felt that their workload was excessive, stressful or unsafe.[21]

Good supervision:[20]

- keeps the trainee safe and well by actively monitoring the trainee's level of stress and ability to cope
- acknowledges the trainee as a person
- clearly defines the roles and responsibilities of the trainee
- addresses the needs of the individual trainee
- ensures feedback is provided in a positive way and addresses weaknesses clearly and unambiguously
- acknowledges and manages factors that may influence the relationship (eg, seniority, gender, race)
- is provided in a supportive, professional but friendly environment, free from any intimidation
- is conducted in the context of building a clinical team in which all members are accorded professional respect.

See also

- *Common challenges for term supervisors*, page 49
- *Managing a trainee in difficulty*, page 50.

22 The role of the registrar in supervising JMOs

Much of the advice in this book can be applied by registrars as well as by senior clinicians, but there are some specific features of supervision by registrars.

Junior medical officers report that most hands-on supervision is provided by registrars, who also provide much of their effective clinical teaching. The relative informality of the supervision provided by registrars is highly valued by junior doctors. Registrars are more like mentors than managers; they are closer to junior doctors in age and experience; they can be easier to approach and more likely to take the time required to answer questions and demonstrate procedures. These features of the registrar–trainee relationship have advantages but also limitations. For example, a registrar is likely to have spent more time engaged in clinical activities with a prevocational trainee and is in a good position to give informal feedback, but this very closeness and informality may inhibit the registrar's ability to make a formal summative assessment of the prevocational trainee's performance.

Here are some tips for both registrars and senior clinicians to make best use of registrar-level supervision:

For the registrar

- Your role in supervision and teaching is highly valued. Enjoy it.
- Supervise junior doctors with the understanding that you would like your supervisors to show you.
- Don't assume a responsibility for supervision above your seniority. The AMO cannot abdicate responsibility for patient care; the term supervisor is responsible for the welfare of trainees in the term. Report problems upwards.
- The Director of Prevocational Training is an alternative source of advice if there are problems between senior supervisor and prevocational trainee that leave you feeling squeezed.
- Take advantage of the *Teaching on the Run* program to learn skills that will be valuable throughout your clinical career — see page 19.

For the senior clinician

- Developing supervisory skills is an important part of registrar training. Delegate supervisory responsibilities to registrars, assess their performance and provide training and feedback.
- Because of their closer experience, registrars will often have more insight into the skills, mental state and progress of your prevocational trainees than you do. Seek their opinion as part of assessing your trainees (but do not substitute their opinion for an exercise of your own judgement).
- The ultimate responsibility for assessing trainees and managing their welfare remains with the term supervisor.
- A useful experience for junior doctors is the opportunity to step up to registrar-level experiences from time to time. Secure the registrar's involvement in planning these opportunities.

23 Mentors and buddies

Mentors are senior clinicians who are paired with juniors to provide guidance and support, and buddies are pairings of junior clinicians (usually one with a bit more experience than the other) for similar purposes. Informal mentoring and buddy relationships develop all the time in clinical practice, but they can also be formalised and deliberately fostered by supervisors as a support to supervision and training.

Providing a mentor or a buddy can be an effective way of:

- introducing a trainee to a new facility or a new term
- helping a trainee in difficulty by giving an extra avenue of support
- building closer links within and between clinical teams.

Generally speaking, a formal mentor or buddy to a trainee should not also be a supervisor of that trainee, as the roles can conflict.

To be a good mentor[18,22]

Do

- Create a safe and supportive environment
- Establish and develop a professional relationship built on mutual respect and trust
- Build rapport and actively listen
- Establish the focus of your mentoring relationship, including an agreement for working together
- Work together to identify, agree upon and realise the trainee's goals
- Empathise. Allow the trainee to express feelings. Remain sensitive and patient.
- Provide constructive feedback and clarify how the trainee would like feedback conveyed
- Ask appropriate and relevant questions that facilitate communication and clarification
- Identify and encourage strengths in the trainee
- Encourage the trainee to think reflectively and critically explore options together

Don't

- Dominate or control the trainee (physically, verbally, psychologically)
- Allow interruptions to your mentoring time or be distracted/interrupted by "more important" issues
- Convey what you think the trainee wants to hear if it is inappropriate
- Harshly criticise or attack the trainee
- Assume that trainees are used to being given constructive feedback — many have undesirable experiences
- Take over, show the trainee what to do, show off your knowledge or insist on the trainee doing things your way
- Create dependency on you
- Show irritation, impatience or annoyance
- Talk more than you listen
- Forget what you experienced when you were learning and developing
- Breach confidentiality

Part four

Term supervision

- **Term supervisors play a key role in the education and training of junior doctors. The system cannot work without them, but ...**

... You are not alone

Term supervisors are not meant to perform their role without support. Responsibility for supervision rests with the whole organisation.

If senior staff feel that they are unable to provide adequate supervision, this should be escalated to managers who are responsible for assessing risk, managing resources to minimise the risk and monitoring outcomes.

The organisation must:

- allow adequate time and training for skilled supervision
- agree on indicators of the quality of supervision and measure these regularly
- have a clear and transparent process for hearing and managing concerns about supervision that may be raised by junior or senior staff.

— see also "The framework of supervision", page 36.

24 The term supervisor's role

A term supervisor leads a specific training term, whether that be one of the core training terms in medicine, surgery or emergency medicine, or one of the elective terms in a wide range of medical specialties, from paediatrics to geriatrics, general practice to neurosurgery.

The term supervisor's role includes:

- preparing and reviewing a term description that defines the trainee's responsibilities and the learning objectives of the term
- defining, documenting and explaining specific knowledge and skills to be developed during the term
- determining the level and proximity of supervision that will be required for each trainee
- ensuring that systems of work and training within the term minimise risks and support the safety of staff and patients
- supporting trainee attendance at formal education sessions and providing effective practice-based teaching
- monitoring trainee progress and providing continual constructive feedback to the trainee
- supporting the professional development of the trainee during the term, advising on concerns, managing problems and giving career guidance
- completing a mid-term formative appraisal of the trainee's performance and an end-term summative assessment.

Term supervisors work with the Director of Prevocational Education and Training (DPET) to manage aspects of the professional development of trainees that run across terms.

A copy of term supervisor position description is shown on page 57.

25 The framework of supervision

Term supervisors manage the welfare, training and assessment of trainees within a training term, but their role is supported by the individuals and institutions listed below.

Director of Prevocational Education and Training (DPET): directs the training of prevocational medical trainees at each training site, and has a more continuous involvement with trainees than their supervisors, who change from term to term. The DPET is a clinician who provides support to supervisors and prevocational trainees independently of line management, and helps solve problems that can arise during training (eg, underperformance, mismatch of expectations, trainee distress, communication issues between trainee and team). The DPET is an advocate for trainee welfare within the hospital. The DPET is responsible for providing a structured education program for prevocational trainees and evaluating its effectiveness. The DPET coordinates the assessment of trainees, co-signing all end-term assessments along with the term supervisor, and certifying interns as eligible for general registration upon the satisfactory completion the their internship. For more on the role of the DPET, see the *DPET guide* (www.ceti.nsw.gov.au).

JMO Management Unit: is the centre for administration of employment, training and education of junior doctors. The JMO unit is the point of continuous contact for trainees throughout their time at a hospital, and JMO Managers are well placed to monitor trainee welfare. The JMO unit works closely with the DPET. It supports and monitor trainees, advocates for quality terms with good supervision, and ensures that training accreditation standards are met. Liaison with the JMO unit is an essential part of the term supervisor role.

Director of Medical Services (DMS): as the senior clinician in charge of managing medical services in the hospital, is the responsible officer for issues affecting the employment, progression and registration of prevocational trainees.

General Clinical Training Committee (GCTC): is a multidisciplinary body overseeing the welfare and training of prevocational trainees within the hospital, providing policy and management support to the DPET. Term supervisors can gain support and solve problems by participating in the GCTC.

Network Committee for Prevocational Training (NCPT): prevocational trainees are assigned to a network of training sites rather than an individual hospital, and the coordination of their training within the network is supervised by the NCPT.

Medical Division of CETI: Previously the NSW Institute of Medical Education and Training (IMET), the Medical Division has statewide responsibility for supporting the education and training of doctors employed by NSW Health. It sets accreditation standards for prevocational training and ensures that trainees are only employed in hospitals and training terms that meet these standards (see www.ceti.nsw.gov.au for more information). The Medical Division advocates for education and training, develops resources (such as this book), and oversees the operation of the training networks. Its *Clinical Supervision Policy* is shown on page 55.

Medical Board of Australia (MBA): from July 2010, national registration of medical practitioners has replaced state registration. Interns must comply with the requirements of the MBA to achieve general registration. If an intern or resident is unfit to practise medicine, the MBA must be notified (this is a relatively infrequent process that involves the DPET, the DMS and the hospital Chief Executive).

26 Australian Curriculum Framework for Junior Doctors

Developed by the Confederation of Postgraduate Medical Education Councils, the Australian Curriculum Framework for Junior Doctors (ACF)[23] outlines the knowledge, skills and behaviours required of prevocational trainees to work safely and effectively in the Australian health system. The ACF is built around three learning areas: clinical management, communication and professionalism.

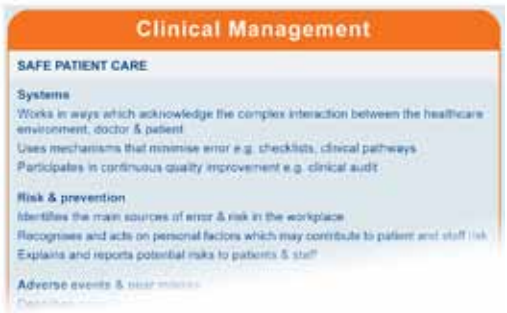
By breaking down the requirements into specific performance elements, the framework makes it easier to plan and assess training in the workplace. It can be used:

- to provide a guide to appropriate goals for each training term
- to review learning opportunities offered by existing training terms, and to identify gaps in training
- to plan development of new training terms
- as a starting point for discussions about innovative approaches to clinical teaching and professional development
- to structure mid-term appraisal and end-term assessment.

The ACF includes a list of specific skills and procedures that trainees should learn over the two years of prevocational training, and a list of common problems and conditions they should learn to assess and manage.

The ACF and supporting resources are available online: www.cpmec.org.au/Page/acfjd-project

The complete Skills and Procedures list from the ACF is shown on page 23.



27 Designing a term

All PGY1 (intern) and PGY2 (resident year one) trainees in NSW must work within training terms accredited by CETI. There is a term description for every term, including nights and relief. CETI provides a template for the development of a term description www.ceti.nsw.gov.au).

A well-designed training term provides the basis for individual professional development and can positively influence the career path of junior doctors.

When developing a term description, the term supervisor needs to ensure that appropriate educational objectives are reflected in the activities and clinical content for that term, and that the workload is equitably distributed, with opportunities for optimal teaching and supervision. Designing a good term description is in large part a matter of designing an effective clinical team with the objectives of good patient care and continuous quality improvement.

The term description should contain at a minimum:

- The name of the term supervisor, the name of the term and the term duration.
- An overview of the team or unit structure and its particular work.
- Any knowledge or skills required before undertaking the term.
- The term objectives (knowledge and competencies to be acquired during the term, expressed in terms of the Australian Curriculum Framework for Junior Doctors). Some of these objectives will be general (eg, “to identify and justify the patient management options for common problems and conditions”) and some may be quite specific (eg, “learn correct technique to scrub, gown and glove”).
- How assessment of and feedback to trainees will occur.
- Unit or team activities, including clinics, meetings and theatre sessions. The trainee’s need for attendance at each session should be made clear.
- Prevocational trainee responsibilities and daily tasks.
- The educational resources available to trainees.
- Staff members responsible for supervision and how to contact them.

The ACF includes a list of specific skills and procedures that trainees should acquire over the two years of prevocational training, and a list of common problems and conditions they should learn to assess and manage. The term supervisor should identify the subset of these specific skills, procedures, problems and conditions that the trainee is likely to be exposed to in the term and list these in the term description.

The term description must be given to trainees at the start of the term. If it is well written, accurate and complete, it can be the foundation of an excellent orientation to the term, and this in itself can prevent many problems.

Term descriptions should be revised regularly (at least annually), on the basis of an effective term evaluation.

28 Term evaluation

The accreditation standards for prevocational training ask that facilities have processes in place to evaluate and improve the quality of training terms.

The standard means of evaluation is to ask trainees to complete a term evaluation form. CETI has a recommended form, which asks trainees to rate:

- Term orientation
- Supervision (by consultant, by registrar, by RMO)
- Workload
- Learning and educational opportunities
- Feedback and assessment processes

The form (see page 59) concludes by asking trainees whether they would recommend the term to their colleagues and inviting them to comment on specific issues.

Evaluation forms are generally distributed and collected by the JMO Management Unit and/or the DPET, a process that allows trainees to give feedback anonymously. Feedback to term supervisors is aggregated or delayed to prevent individual trainees being identified by supervisors, and because a pattern of comment is more significant than the remarks of one person. Feedback collected in this way can give supervisors insights into what aspects of the term are most appreciated or disliked.

As a term supervisor, you should take advantage of the opportunity to discuss this feedback and responsive improvements to the term with the DPET on a regular basis.

There are other effective approaches to term evaluation that can also be used:

- The performance of trainees is also a measure of the effectiveness of the training program in the term. Do you keep track from term to term of how trainees are performing? How often do trainees complete their personal learning objectives in your term? Is there a trend in trainee performance over a series of terms, as measured by standardised assessment tasks?
- Conversation with trainees is a chance to receive as well as to give feedback. Trainees can be reluctant to be critical when speaking with a term supervisor, but can be encouraged to provide positive suggestions for improving or extending the training opportunities within the term.
- Comparing your term description with the term description used by other supervisors who lead similar terms can give you ideas for improvement. If possible, network with other term supervisors so that you can compare and share educational ideas.

Term evaluation by all available means forms the basis of your regular review of the term description.

29 Specific requirements of core terms

The three core terms for prevocational trainees are medicine, surgery and emergency medicine. Term supervisors for these terms need to be aware of the essential minimum training experiences CETI has identified for these terms.

Requirements of a core medicine term

- Term supervisor: specialist physician responsible for patient care.
- Appropriate caseload: considering acuity, comorbidities and patient turnover.
- Patient management ward rounds for the ongoing care of patients conducted with the same senior clinician (minimum PGY3) at least three times a week.
- Immediate senior clinical assistance available at all times.
- Supervision to continuously evaluate aspects of the trainee's history-taking, physical examination skills, discharge planning and communication skills (both written and verbal).
- Supervision to ensure that the trainee safely prescribes therapeutic agents.

Requirements of a core surgery term

- Term supervisor: specialist surgeon responsible for patient care.
- Appropriate caseload, considering acuity, comorbidities and patient turnover.
- Clinical exposure to the range of pre-operative assessment, operative procedures and post-operative care.
- Immediate senior clinical assistance available at all times.
- Daily ward rounds for the ongoing care of patients conducted with the same senior clinician (at least PGY3) at least three times a week.
- The trainee 'scrubs in' to assist with operative procedures for at least four half-day sessions in the term.

Requirements of a core emergency term

- Term supervisor: specialist emergency physician responsible for patient care.
- Continuous clinical supervision in the department at all times.
- Supervision of bedside procedural skills by direct observation.
- Supervision of medical emergency skills to ensure that trainees demonstrate satisfactory participation in a resuscitation team. This can occur in supervised exposure to critically ill patients or in a simulated setting.
- Supervision to ensure that trainees demonstrate the ability to identify urgent priorities in the assessment, referral and management of an undifferentiated acute patient.

30 Meeting accreditation standards

CETI Medical Division sets accreditation standards for prevocational training and monitors the performance of training sites to promote a high standard of general clinical training throughout NSW. The accreditation standards cover the following areas:

- Facility and term orientation
- Supervision
- Professional development
- Training and service requirements
- Formal education program
- Clinicians as teachers
- Assessment and feedback
- Education and Information resources
- Prevocational trainee management
- Prevocational trainees with special needs
- Safe practice
- Promoting prevocational trainee interests
- Supporting prevocational trainees
- Physical amenities

Each training facility is accredited for a maximum of three years after a self-assessment, an on-site assessment by accreditation surveyors and a review of the survey findings by CETI's accreditation committee. Accreditation may be awarded with provisos (conditions of accreditation) aimed at requiring improvements in training.

Term accreditation is based on the written term description, but the actual practice of each accredited term is assessed during accreditation site surveys.

More information about accreditation processes and standards is available at <www.ceti.nsw.gov.au>.

Term supervisors play a key role in meeting the accreditation standards for prevocational training by:

- providing a good written term description
- demonstrating a high standard of supervision (both for patient safety and for trainee education)
- managing the welfare of trainees (providing appropriate hours, conditions of work, professional support and advice).

Sometimes, despite the best efforts of the term supervisor, the quality of training within a term may fall below the accreditable standard. For example, the workload may become too high, or the number of senior clinical staff may fall below the level needed for adequate supervision. In such circumstances, it is the term supervisor's job to seek a remedy, by making representations through the General Clinical Training Committee to the hospital administration. If this does not produce a solution, and if the problem persists, it should be reported to CETI. CETI investigates changes in the circumstances of training terms and works with hospital administrations to find ways to ensure the standards are met.

31 Term orientation

Term orientation — sometimes called term induction — is the key to effectively introducing a new trainee into the clinical team.

Term supervisors are responsible for organising term orientation for new trainees, even if they delegate parts of the orientation to other staff. Junior doctors highly value a formal orientation at the start of a term, preferably the first morning. Not orienting a trainee to the term sends some strong negative messages about the professionalism of the team they are joining. Lack of orientation is often a root cause of later problems that trainees may experience during the term.

It is useful to have a checklist to ensure that orientation is comprehensive. Wherever possible, include a face-to-face handover from the junior doctor leaving the term to the new trainee. A succinct (written or digital) orientation package is an excellent welcome gift. Such packages need regular update with input from junior doctors.

Junior doctors appreciate the participation of senior doctors in the orientation program, but much of it can be overseen by registrars, nursing staff and allied health staff. The benefit of a multidisciplinary orientation is that it immediately begins to meld the junior doctor into the the team. Trainees need to know about all the team members, not just the medical staff.

Orientation provides the term supervisor with the opportunity to review the trainee's current level of knowledge and experience and to develop an individualised plan to meet their particular needs.

Benefits of a successful orientation extend not only to the junior doctor, but to the whole clinical unit. With a multidisciplinary approach, teamwork and collaborative relationships are promoted and interns can be better supported. In addition, clinical care of patients will benefit from the use of standard procedures and protocols.

Checklist for term orientation

As well as providing a written term description, the term supervisor must discuss these items with the trainee, or ensure that they are discussed by someone else:

1. The major focus and goals of the clinical unit and the expectations of the junior doctor's role:
   - roles and responsibilities
   - expected daily tasks
   - individual registrar and consultant preferences with respect to management
   - hints for successful interactions with other staff members
   - procedures for ordering and following up tests, investigations, consults
   - other administrative procedures in the unit
2. Term learning objectives and skills training goals
3. Supervision needs and the process of performance assessment:
   - initial interview
   - mid-term appraisal
   - end-term assessment
4. General information about work practices, protocols and guidelines as they apply to this term.

32 Trainee assessment

Junior doctors highly value their interactions with senior doctors. In an ideal world, there would be plenty of time for discussion and feedback between term supervisors and trainees. In practice, time is limited. However, at a minimum, term supervisors must spend enough time observing trainees to make a meaningful assessment of their performance. It is the term supervisor's responsibility to complete a mid-term appraisal and an end-term assessment of every trainee.

Purposes of assessment

1. Assessment should provide trainees with feedback about their performance that will help their development as doctors. This is the formative assessment purpose. Assessment should help trainees identify their strengths and weaknesses, and give them ideas about how to improve.
2. Assessment should identify strengths and weaknesses in the training program so that it can be improved. This is the educational development purpose. Good assessment systems shed light on the performance of the training program as well as the trainees, and can be used to guide improvements.
3. Assessment should provide evidence that trainees are achieving the competencies required for their future responsibilities as doctors. This is the certification and registration purpose. A good assessment system should assure us that doctors are meeting certain standards of practice and competence before advancing to higher levels of responsibility.
4. Assessment should identify underperforming trainees so that appropriate remedial action can be taken early, and so that, in serious cases of underperformance, the trainee is prevented from advancing to the next stage of training before remediation. This is the safety purpose, protecting both patients and trainees.

Three key meetings for assessment

There are three key meetings for the purposes of formal assessment: an interview at the start of term, a mid-term appraisal meeting, and an end-term meeting to complete the final assessment.

1 Start of term interview

The interview at the start of term is an aspect of term orientation that the term supervisor should conduct personally.

In this meeting, the term supervisor reviews the term description with the trainee and discusses:

- the major focus and goals of the clinical unit and the expectations of the trainee's role
- term learning objectives
- supervision needs and the processes of performance assessment.

During the interview the term supervisor should discover:

- The current level of experience of the trainee (what terms they have already completed, or what undergraduate clinical experience they have). If the trainee keeps a portfolio or logbook, the supervisor will find it useful to review it.
- The trainee's personal training objectives (what they hope to learn this term, and what career path they hope to pursue).

The aim of the interview is to develop a shared understanding of the individual learning pathway of the trainee. The learning objectives in the term description should be translated into specific personal learning objectives that the trainee is committed to achieving and that the supervisor is able to support. Assessment throughout the term will then be based on the trainee's level of achievement of these personal objectives. The trainee should be encouraged to keep a personal logbook of their progress during the term.

If there is a mismatch — for example, if the trainee has objectives that cannot be met within the term, or if the supervisor doubts that the current skills of the trainee are sufficient for the immediate duties of the term — it is better for these issues to be identified early. Trainee expectations have to be managed honestly, including bringing them to understand that in a workplace-based training system centred on patient care, compromise is required. If the trainee has skill deficits, the term supervisor has to come up with a remediation plan (you can't send a trainee back back to the bench and call for a new player). Usually the trainee will be fully committed to overcoming any weaknesses, if these are identified clearly. Remember, the DPET is available to help with ideas and to negotiate a practical solution.

2 Mid-term appraisal

This takes place at about week 5 of the term. The aim is to review the trainee's performance, reflect on strengths and weaknesses, and plan the future direction of the term. The mid-term appraisal is a formative assessment, part of the educational process intended to assist the trainee's professional development.

While it is the term supervisor's responsibility to complete the mid-term appraisal, consulting other members of the clinical team to form a picture of the trainee's performance during the term is recommended. It is also advisable to use a range of specific assessment tasks; these might be case presentations, observations of procedural skills, simulated patient exercises, research assignments, review of discharge summaries or other methods appropriate to the term. In general, assessment should be based on a range of observations, preferably by a range of observers.

Effective assessment at mid-term and end-term

- Accurate evidence
- Constructive discussion
- Co-operation to develop a plan to specifically address any problem areas.
- Specific methods of assessment (such as, direct observation of procedural skills [DOPS], mini clinical examination exercise [Mini-CEX], or case-based discussion)
- 360° assessment (consult the clinical team)
- Assignments
- Whatever you do: repeated observations and multiple methods of assessment are best.

The term supervisor should allow half an hour for the mid-term appraisal interview, which should be conducted in a private space free from interruptions. The trainee completes the self-assessment form before meeting with the term supervisor. Self-assessment provides a basis for discussing progress and planning the future direction of training during the term. The trainee is asked to outline personal strengths and achievements and identify weaknesses or needs for further development. The supervisor then offers feedback in the same manner, before completing their written assessment of the trainee.

In some circumstances (such as relief terms in which the trainee has moved frequently from team to team) the term supervisor may not have sufficient knowledge of the trainee to form a reasonable assessment even after consulting other staff members. In this case, the DPET should be consulted, and the DPET may agree to assume the responsibility for completing the assessment.

When weaknesses and problems in the trainee's performance are identified at the mid-term appraisal, the term supervisor should work with the trainee to develop an action plan (see page 54). An action plan may also be suitable for the trainee who is performing well as a means of maximising their development during the term.

3 End-term assessment

The end-term assessment is completed in the final week of term. The process is very like the mid-term appraisal. Again, the term supervisor should allow half an hour for the interview. For year 1 trainees, this assessment is required by the Medical Board for registration. For year 2 trainees, the assessment forms part of their record of achievement and will be useful in evaluating their progress to vocational training.

This is a summative assessment of the trainee's performance at the end of term. Gaps or weaknesses in performance revealed earlier are only relevant if there are reasonable grounds for believing that the trainee is still performing at that level. If end-term assessment shows that the trainee is underperforming, the DPET should be informed so that a remediation plan can be instituted.

A study of over 3000 assessment forms completed in New South Wales in 2009 found that at end-term, supervisors identified less than 1% of trainees as performing at "borderline" or "below the expected level".[24] It is thought that supervisors are reluctant to document a negative assessment of trainees that might affect their career progression. In reality, the effect of a negative assessment is to highlight a potential problem and draw increased resources to its solution. The training system as a whole is reluctant to lose trainees at this stage of training, and the DPET, hospital administration, CETI and the Medical Board will work hard to bring any trainee up to standard. The practical disadvantages of not recording a negative assessment when one is justified are many:

- Trainee inadequacies may not be addressed because they have not been flagged. The trainee carries them on to the next term.
- When weaknesses are exposed later, the trainee has difficulty accepting criticism because of previous "good reports". This can inhibit learning and make the remediation of weaknesses more difficult.
- Unidentified weaknesses in trainee performance pose a risk to patient safety.

33 Action plans

Action plans are a formalised means of developing an individual training program. They are particularly important as a means of overcoming identified deficiencies in the performance of a trainee, but they can be just as useful as a means of enhancing the training of trainees who are performing well.

An action plan should be developed in consultation with the trainee and should represent an agreement between trainee and supervisor on the future path of training. It will typically include actions and commitments for both parties. Assistance from the DPET may be required when designing an action plan.

Action plans might call for the trainee to participate in structured training sessions, individual learning programs or supplementary tutorials, or to observe or participate in particular procedures.

As a simple example, prescribing difficulties may require some focused study in pharmacology with additional practical assistance from the team pharmacist. Close supervision of all prescribing by the registrar or CMO may be required until a further review to ensure that the appropriate skills and knowledge have been acquired.

For some trainees, an action plan may give attention to language or communication skills or other aspects of personal development.

An action plan template for an underperforming trainee is provided on page 54.

34 International medical graduates*

Term supervisors are responsible for assessing doctors who qualified overseas and who are undergoing AMC-supervised training to secure general registration. This group of doctors is heterogeneous in their previous medical education and clinical experience. Many face special challenges:

- language and cultural differences.
- differences in medical education, clinical practice and disease patterns between countries.
- some may not have practised medicine for some years while trying to pass the AMC examination
- some may have been specialists in their previous country and find it difficult to practise general medicine again
- some may have held prestigious positions in their former country and now have to start again at the bottom of the ladder
- some have significant financial and family commitments
- as migrants, some may feel isolated and lack social support.

Showing some understanding of these difficulties can go a long way towards easing the transition into the Australian medical workforce.

Orientation is particularly important. The term orientation may have to be more detailed than it would be for a local graduate. Determining levels of knowledge and experience and providing clearly formulated work plans may avoid problems.

In terms of teaching and assessment, these areas require special attention:

- **Communication:** Both conversational and medical English may be weak. Provide lists of abbreviations and their meanings. Ensure that instructions received have been understood — don't assume. Refer the trainee for specific language support early if this seems to be an issue.
- **Procedures:** Don't assume knowledge. In some countries, basic procedures are performed by nurses, not doctors.
- **Documentation:** Provide and explain clear models; give them a system for writing admission and discharge summaries.
- **Ward duties:** Again, Australian practices are differ from those in many countries. It may help to have the registrar work with the trainee to write a daily task list until the trainee is familiar with the duties and priorities that are expected.

Despite the challenges, AMC graduates can be a most rewarding group of trainees to work with, because with appropriate assistance they tend to flourish as clinicians.

Useful resources

*This chapter is based on advice in the *Hunter New England Term Supervisors Handbook*.[25]

See also: Couser G. Twelve tips for developing training programs for international medical graduates. *Med Teacher* 2007; 29: 427–430.[26]

35 Common challenges for term supervisors

The goal of supervision is to bring out the best in every trainee. There are often challenging moments on the way to this goal. The challenges, like the trainees, are individual and require solutions tailored to the circumstances. Many problems can be avoided by carefully orienting the trainee to the term, because this will prevent many misunderstandings and alert the term supervisor to issues that may need management.

Many issues may affect a trainee's performance. Some of the more common issues (and potential responses) are listed below. The first response to any problem should usually involve face-to-face discussion with the trainee. If the issues involved are sensitive, this should be conducted in a private location free from interruptions at a time when neither the supervisor or the trainee is distracted, or overstressed. If the issues are serious or if attempts to resolve the issues are failing, it is appropriate to consult the DPET.

Challenges and solutions

The trainee with communication problems. Does the trainee recognise that communication is a problem? If yes, remediation can be relatively straightforward (language courses, writing courses, conversational practice, providing scripts or templates to model effective communication practices, providing a mentor or buddy). If no, the issue is more complex, because the solution has to begin with giving the trainee insight into the problem. For example, members of the clinical team may report that the trainee is impolite and uncommunicative, while the trainee considers that he is efficient and focused. Readjusting trainee perceptions involves developing his or her empathic ability (to see things from another's point of view). The effective technique for this will depend on the character of the trainee.

The trainee uninterested in this term's area of medicine. It is best to identify this at the beginning of the term and plan accordingly. In some instances, the trainee's lack of interest will be based on a misconception of the content of the term or on a failure to appreciate its relevance to their area of interest. In many cases, the term supervisor can highlight aspects of the term that will be of interest to the trainee (provided that these interests have been identified in the start of term interview). In others, an appeal to the trainee's sense of responsibility to the team will motivate them.

The overconfident trainee. Overconfidence is potentially dangerous, and it is important to provide a reality check at an early stage, perhaps by asking the trainee to advise on a hypothetical case and then providing a critique of their management plan, or by highlighting to them the potential consequences of their overconfidence in relation to a real patient. This should not be done in a way that will embarrass the trainee publicly.

The perfectionist trainee. Some trainees are so determined to do everything perfectly that they cannot meet realistic deadlines and are in danger of burning themselves out. It is important with these trainees to develop an appropriate priority list and work on realistic time budgeting.

36 Managing a trainee in difficulty

Any of the "difficult" trainees described on the previous page, and many others besides, may become a "trainee in difficulty" — somebody who is not progressing as they should and potentially placing themselves and others at risk.

Being a junior doctor in training is challenging. It is generally agreed that about 10% of trainees experience some difficulties during prevocational years. Most problems can be resolved if they are appropriately identified and managed, with trainees becoming competent clinicians over time.

The general approach to dealing with trainees in difficulty rests on three principles:

- patient safety should always be the primary consideration
- trainees in difficulty require supervision and support
- prevention, early recognition and early intervention are always preferred over a punitive approach in dealing with identified issues.

When a term supervisor encounters a trainee in difficulty, he should consult the DPET without delay. Experience has shown that simple interventions can be very effective if made early enough.

Important: Because trainees move on from term to term and from hospital to hospital, it is important to communicate any ongoing concerns about a trainee to the DPET and the network JMO manager so that there is continuity of management.

IMET's *Trainee in Difficulty* handbook[27] provides more detailed practical advice on managing junior doctors who are experiencing difficulties.

It provides information about:

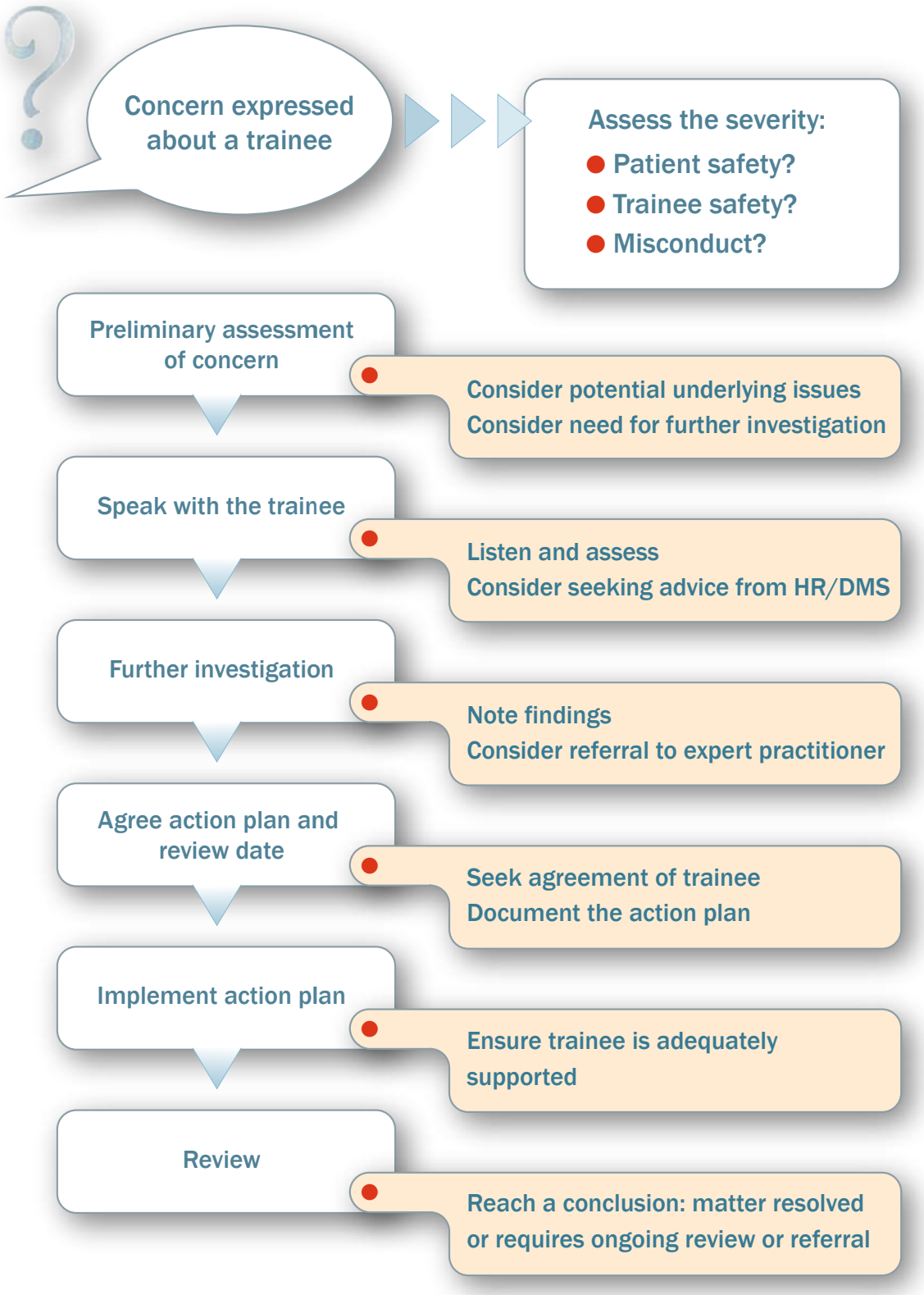
- early signs of trainees in difficulty
- how trainees experiencing difficulties present
- assessing the severity of the situation – flags for immediate action and referral
- the range of underlying issues
- speaking to the trainee and other key individuals
- formulating, implementing and reviewing an action plan to address identified issues
- importance of documentation.

Useful resource

The *Trainee in Difficulty* handbook[27] is available as a pdf file on CETI's website: <www.ceti.nsw.gov.au>.

Managing a trainee in difficulty

The management algorithm below is taken from the *Trainee in Difficulty* handbook.[27]



37 Beyond the term supervisor role

Many senior clinicians find leading and mentoring to be one of the most satisfying parts of their job. If you enjoy helping junior doctors develop their professional careers, you might like to consider the role of Director of Prevocational Education and Training.

Principal responsibilities of the DPET

- Develop, coordinate and promote the clinical training of prevocational trainees, in association with prevocational trainee staff management, the General Clinical Training Committee (GCTC) and the Network Committee for Prevocational Training (NCPT).
- Support term supervisors in their role.
- Participate in the education of prevocational trainees.
- Assist the GCTC to evaluate training programs, clinical educators and educational resources.
- Promote professional responsibility and ethics among prevocational trainees.
- Play a major role in the planning, delivery and evaluation of prevocational orientation programs including acting as a resource for clinical teachers.

For more information, consult the *DPET guide*.[28]

Useful resource

The *DPET Guide* is available as a pdf file on CETI's website: <www.ceti.nsw.gov.au>.

Part four

Resources

- Prevocational trainee action plan template.
- CETI's Clinical supervision policy: outlines mandatory requirements for clinical supervision of prevocational trainees.
- Term supervisor position description.
- Term evaluation form

More resources, plus updates to this handbook, are available online: www.ceti.nsw.gov.au

Prevocational trainee action plan

Trainee name	**Level**	**Current rotation**	**Term supervisor**	
Person completing this action plan			Plan date	Review date

Agreed actions	Expected outcome*	Person responsible	Review date
1			
2			
3			
4			

Referred to network committee:	☐ Yes	☐ No	Referral for specialist assistance:
Involvement of DMS	☐ Yes	☐ No	
Involvement of HR	☐ Yes	☐ No	

Signed:

Trainee	Term supervisor	DPET
Date	Date	Date

** Ensure that planned outcomes are "SMART": Specific, Measurable, Achievable, Relevant, Timeframed.*
Ensure that the trainee has adequate support.

CLINICAL SUPERVISION POLICY

Policy Number:	DOC08/8577	**Responsible Officer:**	Head, SSOD	**Date Last Amended:**	20 Nov 2008
Date of Effect:	20 Nov 2008	**Approved by:**	Prevocational Accreditation Committee	**Currently under review.**	
TRIM No:	DOC08/8577				

Context:

The NSW Institute of Medical Education and Training (IMET) recognises that adequate and appropriate supervision is critical to the training and development of prevocational trainees. Supervision of prevocational trainees is imperative to ensuring not only their safety but the safety of their patients.

Scope:

This policy is applicable to all facilities and accredited terms where prevocational trainees are employed. The policy statements are valid whenever a prevocational trainee is on duty.

Policy Statements:

1. A PGY2 trainee must not be the most senior doctor in a facility.
2. Clinical supervision must:
   - provide a safe environment for patients and prevocational trainees
   - ensure optimal training of prevocational trainees
   - allow for increasing opportunities for independent decision making
   - be readily available at all times.
3. The proximity of clinical supervision required in each work situation is determined by:
   - the medical facility setting
   - the type of term
   - the knowledge, experience and skill level of the prevocational trainee
   - the scope of practice
   - the complexity of patient care required.
4. Supervisors must:
   - make themselves known to the prevocational trainees
   - have at a minimum greater clinical experience than a PGY2 trainee
   - be aware of their responsibilities in providing clinical supervision
   - have demonstrated competencies to provide clinical supervision
   - meet conditions as defined by the facility for suitability of supervision
   - be registered with the NSW Medical Board
   - actively assess the level of supervision required.
5. Supervisors supervising a PGY1 trainee must be awake and onsite at all times.
6. Supervisors supervising a PGY2 trainee can be asleep but must still be onsite and readily accessible.
7. A specialist opinion must always be available.
8. The facility must:
   - ensure appropriate levels of clinical supervision are provided at all times
   - ensure supervisors are aware of their responsibilities in providing clinical supervision
   - ensure the process for contacting supervisors is clear to all involved
   - ensure supervisors have the skills, experience and training to provide safe and effective clinical supervision
   - monitor the workload of supervisors to ensure they can effectively fulfil their role as a clinical supervisor
   - assess the suitability of a doctor to provide clinical supervision when there are conditions placed on their registration
   - ensure there is continuity of responsibility for supervision during periods of supervisory leave
   - provide the term supervisor with a position description in line with the NSW IMET Term Supervisor position description template
   - provide position descriptions for all staff responsible for supervising prevocational trainees that

clarifies their roles and responsibilities for supervision
- evaluate the adequacy and effectiveness of prevocational trainee supervision.

9. Term supervisors must ensure that their contact with the each prevocational trainee is sufficient to permit a valid assessment of the prevocational trainee's performance.
10. Term supervisors must fulfil the roles, responsibilities and criteria outlined in the NSW IMET Term Supervisor position description template.
11. If the supervisor is not present on site, supervision must be delegated by the supervisor to another suitably experienced practitioner on site.

Definitions:

AMC Graduates – An overseas trained doctor who has passed the Australian Medical Council (AMC) Clinical Examination and meet all requirements for allocation by NSW IMET. is required by the Medical Board to undertake a period of supervised training. The position they hold is equivalent to a PGY1 trainee.

IMG – An international medical graduate who is directly employed by a facility. They have conditional registration with the NSW Medical Board. They are doctors who have obtained their medical degree outside of Australia.

Local Graduates – Medical students who have completed their medical degree in an Australian university.

PGY1 (Postgraduate Year 1) – is the first year of workplace training following the completion of medical school or AMC graduation. The year is also referred to as internship.

PGY1 Trainee – An AMC Graduate, IMG and local graduate undertaking supervised training in their PGY1.

PGY2 (Postgraduate Year 2) – is the second year of prevocational training after completing PGY1.

PGY2 Trainee – An AMC Graduate, IMG and local graduate undertaking supervised training in their PGY2.

Prevocational Trainee – A Prevocational Trainee includes PGY1 trainees, PGY2 trainees and AMC graduates undertaking supervised training.

Clinical Supervision – Direct or indirect monitoring of prevocational trainees by a more senior medical practitioner to:
- ensure practices are performed safely for both patients and trainees
- provide prevocational trainees with training, feedback and assessment of clinical procedures and patient care.

Supervisor – A medical practitioner who is responsible for ensuring the clinical supervision of prevocational trainees. A supervisor must be a medical practitioner with general registration with the NSW Medical Board and have no prior history of removal from any register for disciplinary reasons under any jurisdiction. At a minimum their clinical experience must be greater than that of a PGY2 trainee and preferably greater than a PGY3 trainee.

Term Supervisor – A senior medical practitioner designated to be particularly responsible for the orientation, supervision and coordination of clinical training and performance assessment of prevocational trainees attached to his/her term.

Term – The specific clinical team, service or unit attachment in which prevocational trainees work and in which clinical training takes place. Each of these represents a term for training purposes and each must be accredited in order to receive prevocational trainees.

References:

- NSW Medical Board – *Internship and AMC Supervised Training Policy*
- PMCQ – *Supervision Policy for Interns in Accredited Facilities (policy number 4.4)*
- Commonwealth Department of Health and Ageing – *National Training and Assessment Guidelines for Junior Doctors*

Supporting Documentation:

- NSW IMET – *Standards of Education, Training and Supervision for Prevocational Trainees and Post AMC Supervised Training*
- NSW IMET – *Term Supervisor Position Description*

Position description

Position title:	**Term Supervisor**
Name of hospital:	*To be completed by employing hospital*
Reports to:	Director of Prevocational Education and Training
Version:	DOC09/970

Mission of hospital

(2-3 sentences to be completed by employing hospital)

Role of Term Supervisor in achieving the hospital mission

(2-3 sentences to be completed by employing hospital)

The Term Supervisor is responsible for the welfare of prevocational trainees allocated to their team or unit. Their key roles are ensuring appropriate supervision for patient safety, providing training to meet the learning objectives of the term, monitoring trainee progress and assessing trainee performance.

Key relationships

- Prevocational trainees and attending medical officers
- Director of Prevocational Education and Training
- Chair of the Network Committee for Prevocational Training
- Chair of the General Clinical Training Committee
- General Manager
- Administrative staff as required

Key roles and responsibilities

Patient safety

- Employs strategies to ensure the safety of care, including combinations of graded supervision, training and personal support for the prevocational trainees assigned to the term.

Trainee welfare

- Coordinates trainee activities across the term.
- Determines the level and proximity of supervision required for each prevocational trainee in each work situation.
- Ensures that the systems of work and training minimise risks and support the safety of prevocational trainees.
- Discusses issues such as grievances and career guidance with prevocational trainees.
- Encourages prevocational trainees to develop progressively increasing independence.

Education and training

- Prepares and reviews a term description in consultation with other attending medical officers in the team, the Director of Prevocational Education and Training, Junior Medical Officer Management and prevocational trainees. The term description describes the responsibilities and accountabilities of the prevocational trainee, specifies the skills required by the prevocational trainee to function safely and defines the specific knowledge and skills to be gained or enhanced during the term.
- Discusses training goals and expectations with the trainee at the beginning of term and ensures that a clinical orientation to the term is provided.
- Develops the educational program available to trainees during the term, supports attendance by prevocational trainees at educational events and provides effective practice-based teaching.
- Monitors the progress of prevocational trainees and provides

continuous constructive feedback to guide their professional development.
- Encourages attending medical officers to provide continuous teaching, supervision and constructive feedback to prevocational trainees.
- Provides formal documented assessment at mid-term and the end of term. These two formal assessments begin with the trainee's self-assessment and are developed in consultation with attending medical officers, registrars, nurses and other professional staff. Assessment includes planning and documenting actions to improve trainee performance.
- Intervenes when necessary to correct gaps or weaknesses in the knowledge or skills of prevocational trainees.
- Informs the Director of Prevocational Training if a prevocational trainee appears to be experiencing difficulty with work or the training program.

Skills, knowledge, experience competencies and behaviours

The Term Supervisor must be an attending medical officer (AMO) at the hospital with AMO responsibility for providing patient care within the scope of the term.

Term Supervisors must have:

- an understanding of the concepts of adult education, performance monitoring and quality improvement
- superior interpersonal skills
- a commitment to the mission of the Institute of Medical Education and Training (IMET) and the ability to present and explain IMET goals.

Performance evaluation

The performance of the Term Supervisor will be evaluated annually by the General Clinical Training Committee (GCTC) with reference to:

- DPET feedback
- Prevocational trainee feedback
- Efficiency of activities
- Performance indicators (to be developed by the GCTC)

Verification

This section verifies that the position holder and supervisor have read the above position description and are satisfied that it accurately describes the position.

Position Holder

Signature.....

Date.....

Supervisor

Signature.....

Date.....

Prevocational term evaluation form

<Network Name>

Thank you for your hard work this term. Please evaluate the term by answering the questions below.
Your feedback will help ensure that education, training and service arrangements are appropriate and continue to improve.

Hospital:	**Term No.:**	**Term name:**
Level (PGY1, PGY2, AMC):	**Clinical year:**	**Term Supervisor:**

ORIENTATION				
○ Was orientation offered before starting the term?	☐ Yes		☐ No	
○ Rate the orientation session and materials supplied	☐ Highly useful	☐ Useful	☐ Not useful	☐ Not applicable

SUPERVISION				
○ Most supervision and guidance was provided by	☐ Consultant	☐ Registrar	☐ Resident Medical Officer	☐ Other
○ Rate your overall supervision in this term				
• By Consultant	☐ Highly useful	☐ Useful	☐ Not helpful	☐ Not available
• By Registrar	☐ Highly useful	☐ Useful	☐ Not helpful	☐ Not available
• By RMO (if applicable)	☐ Highly useful	☐ Useful	☐ Not helpful	☐ Not available

WORKLOAD				
○ Rate your overall workload in this term	☐ Excessive	☐ Busy	☐ Reasonable	☐ Insufficient

LEARNING and EDUCATION OPPORTUNITY				
○ Did the term meet the learning objectives stated in the term description?	☐ Yes		☐ No	
○ Were you offered formal teaching sessions and tutorials in this term?	☐ Yes		☐ No	
○ Rate the overall education and learning opportunity you received in this term, including clinical supervision	☐ Highly useful	☐ Useful	☐ Not enough	☐ Not satisfactory

ASSESSMENT				
○ Rate the overall feedback and assessment process	☐ Highly useful	☐ Useful	☐ Not useful	☐ Not performed

OVERALL RATING				
○ I have gained clinical skills and had good educational opportunities in this term	☐ Strongly agree	☐ Agree	☐ Disagree	☐ Strongly disagree
○ Would you recommend this term to your colleagues?	☐ Yes		☐ No	

Thank you very much. Please use the back of this form to provide comments on any specific training issues raised by your experience in this term. Your evaluation will help us to maintain a standard of excellence in our training program.

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The Superguide

a handbook for supervising doctors in training

This is a practical handbook designed to help senior medical staff supervise prevocational trainees (junior medical officers).

It provides information about:

- supervising junior doctors in ways that contribute to the safety and better medical care of patients
- effective methods of contributing to the education, welfare and professional development of junior doctors
- implementing the Australian Curriculum Framework for Junior Doctors
- assessing and certifying the competence of junior doctors.

This handbook is not a policy document. It gives tips and suggestions based on the published evidence of what makes good supervision and the knowledge of many experienced supervisors and directors of training in New South Wales.

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