# Outcome of proceedings of the National Supervision Summit

## Melbourne, 20 March 2013

An initiative of the Committee of Presidents of Medical Colleges (CPMC), the Confederation of Postgraduate Medical Education Councils (CPMEC), and Medical Deans Australia and New Zealand Inc (MDANZ).

Report assembled by Kevin Forsyth

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# Purpose

### Outcomes

The summit aims were to discuss and reach agreement on:

1. The aspects of clinical supervision that need to remain discipline and subdiscipline specific and those that are generic across the medical education and training continuum.

2. The adequacy of the generic clinical supervision support resources that have been developed for use across medical education and training, how to address the gaps, and determining a process of sharing clinical supervision support resources across medical disciplines and the training continuum.

3. A cost-effective sustainable model to support and develop clinical supervisors and improve the quality and consistency of clinical supervision across the education and training continuum.

The Summit is an outcome of collaboration between CPMC, CPMEC and Medical Deans in a supervision project designed to better support supervisors of medical students and trainees working in clinical settings.

# Summary and recommendations

Clinical supervision is a critical issue for clinical training and patient safety. Supervision is a fundamental component of medical practice. There are two key challenges: the capacity of the system needs to be increased and the quality of supervision needs to be improved. Recognising these needs, the National Supervision Summit attracted support and interest across a wide range of organisations from all jurisdictions.

In improving both the medical education system and enhancing patient safety and quality, the central role of clinical supervision should be recognised. We need to make supervision sustainable into the future and to make a clear business case for supervision and system change.

A number of recommendations arose from the Summit. These are for subsequent consideration by CPMC, CPMEC and MDANZ.

### Capacity

Increasing the supervision capacity of the system to deal with growing student and trainee numbers will require unlocking the private sector; fostering, training and supporting the supervisors of the present and future, ensuring time for supervision, and developing incentives for existing staff.

Recommendations:

- That supervision remains a core element of clinical activity, without specific funding to individual supervisors or episodes of supervision.
- That IHPA's work on activity-based funding determines cost and establishes a funding base to enable clinicians to allocate sufficient time to supervision.
- That HWA and IHPA continue to develop funding models to encourage private sector involvement in clinical supervision.
- That MDANZ and Colleges develop models to involve the private sector in supervision, providing for medium and long-term student placements.
- That Universities, the PMCs and Colleges utilise generic supervision courses at all levels of education to train current clinicians, trainees and the next generation of medical students in supervision.
- That all medical education providers develop an agreed system to accredit generic supervisory training courses that meet AMC standards, hence reducing duplication.

### Incentives and drivers

Incentives and drivers for existing staff will help to increase the capacity of the system and to improve the standing of supervision within the system.

Recommendations:

- That Colleges recognise supervision training and activity through CPD points.
- That hospitals make supervision part of clinical job descriptions and performance reviews.
- That Colleges and/or hospitals establish supervision awards to recognise and encourage excellence.

- That AMC standards are strengthened to mandate or recommend supervisor–student ratios and the proportion of time spent in supervision.

### Training

Training is important to improve the effectiveness of supervision, to support clinicians who do not feel comfortable in a supervisory role, and to reduce the medical workplace culture of bullying in supervision.

Recommendations:

- That Universities, Colleges and/or hospitals mandate training for supervisors and establish KPIs around supervision training embedded across all levels of training.
- That AMC standards are strengthened to mandate supervision training or the establishment of KPIs around training.
- That health services actively support the training of their clinical staff in supervision.
- That generic supervisory training courses are readily accessible in a variety of modalities.

### Networking and resources

Along with training, supervisors need continuing support and networking to foster their supervisory role and to gain access to resources.

Recommendations:

- That a clinical supervision website is established. The website would provide information and links about training and supervision resources and about existing and pilot training or supervision programs. It would also provide a forum for discussion on a range of topics around supervision.
- That the National Supervision Summit be held annually to provide a forum for new programs and to discuss current supervision needs and solutions
- That HWA give consideration to support the mapping of existing supervision resources and programs and support the roll out of effective examples.HWA have supported a number of valuable supervision resources and developments. Harmonisation of existing supervisor training programs through this process would reduce training burden on the training organisations and the health service.

### KPIs and feedback

Supervision KPIs will help to drive change and provide a quantitative measure of improvement.

Recommendations:

- That hospitals and employers ensure adequate clinical supervision by the provision of KPIs both within individual position descriptions and departmental reporting requirements. This would include the proportion of staff time spent in supervision and the percentage of supervisors who are trained.
- That Universities, Colleges and/or hospitals develop standardised systems to elicit accurate, useful student/trainee feedback.
- That student/trainee feedback is used to improve the quality of supervision.

## Research

Research is needed to establish a business case for supervision and to further support the development of effective models for supervision and funding.

Recommendations:

- That ACSQHC and/or HWA identify funding resources to promote the conduct of research into the correlation between healthcare safety and quality and supervision practices

- That ACSQHC promote the development of a national safety and quality standard around supervision

- That ACSQHC and/or HWA identify funding resources that promote the conduct of research into the correlation of supervision KPIs with patient safety and quality outcomes

- That HWA and/or IHPA identify funding mechanisms/processes that promote the conduct of research into optimum supervisor-student ratios.

## Future steps

The three medical training organisations, CPMC, CPMEC and MDANZ, will collectively consider the recommendations and issues raised in this report.

# Background

The expansion in medical knowledge and the range and complexity of investigations and treatments means it is no longer possible to cover everything needed for unsupervised clinical practice in a university-based medical course. A significant focus of undergraduate training is now on preparation for internship, with an understanding that once medical students become interns they will continue their training for at least four to five further years as interns and specialist trainees within the health sector.

During this period of student and trainee learning, clinical supervisors are the backbone of medical training.

Changes in the health sector are impacting on the practice of clinical supervision and on clinical supervisors. Pressures include:

- much shorter admissions times, which has reduced opportunities for trainees to spend time with patients and follow them longitudinally
- shorter working hours for trainees
- rising student numbers but static supervisor numbers, resulting in increasing trainee–supervisor ratios
- increasingly complex training programs
- insufficient training or support for clinicians to become supervisors; clinicians are primarily trained for individual clinical practice, not supervisory skills
- increasing numbers of international medical graduates (IMGs).

A number of changes and programs are being developed to address these pressures:

- The Australian Medical Council (AMC) has developed standards around clinical supervision. Over time, there will be greater requirements for supervisors to be trained and accredited to agreed standards.
- The clinical supervision support partnership (CSSP) program of MDANZ, CPMEC and CPMC has developed a framework for generic training of supervisors, with a website providing information and e-modules for supervisors (www.clinicaleducators.org).
- Postgraduate medical councils and specialist training colleges have changed the structure and rigour of their training programs to include such strategies as rotation learning plans, evaluation after each rotation, workplace-based and online assessments, *e*-log books etc.
- Private hospitals are increasingly providing clinical exposure for students and trainees and wish to participate more formally in medical training.
- A National Clinical Supervision Competency Framework is being developed by Health Workforce Australia (HWA) to provide a guide to training programs for supervisors.
- HWA have resourced many supervisor support programs and have undertaken considerable work in mapping supply and demand and advised on better ways to coordinate and support medical training throughout the training pipeline.

The National Supervision Summit aims to examine what can be done to address the shortages in clinical supervisor numbers and to better harmonise and improve supervisor training.

# Presentations

## Introduction

### Professor Kevin Forsyth, Director, Clinical Supervision Support Partnership of MDANZ, CPMEC and CPMC

The changes we are seeing in the medical sector are bringing increasing pressure to bear on clinical supervisors. [See *Background* above.] It is important that we find ways to deal with these pressures to protect and support the critical role of supervisors, and to ensure we have the supervision resources needed for the next generation of students and trainees.

In doing so we are looking not just to the future of medical education but to the future of medical care.

A recent review of medical training in the United Kingdom [Temple J (2010). *Time for training: a review of the impact of the European working time directive on the quality of training*] said that:

> Training is patient safety for the next 30 years.

The purpose of this meeting is not to complain to each other about the difficulties and challenges in clinical supervision, it is about developing productive ways forward to deliver coordination and harmonisation across the system.

It is therefore encouraging that the summit has attracted support across the system: from the Committee of Presidents of Medical Colleges (CPMC), the Confederation of Postgraduate Medical Education Councils (CPMEC) and Medical Deans Australia and New Zealand Inc (MDANZ). I thank them for their support.

## History of clinical supervision

### Professor Richard Smallwood AO, University of Melbourne

In looking at the challenges now facing us in clinical supervision, it is useful to look at how far supervisory practices have come.

I began my training half a century ago. Before Flexner [Flexner A (1910). *Medical education in the United States and Canada: a report to the Carnegie Foundation for the advancement of teaching*], medical training was highly idiosyncratic with each practitioner having their own approach. After Flexner, training began to be bioscience based, rational curricula were established, and school accreditation started. It began to be a reasonable bet that a doctor trained in one part of the country would have similar knowledge and practice to one trained elsewhere.

When I did my training in the 1950s and 60s, the University of Melbourne had a six-year course. The first year was pre-med and included chemistry, physics and so on. This was followed by two years of anatomy, chemistry and physiology. The teaching approach during these years was definitely ‘shape up or ship out’. No notice was taken of individual students.

We had little idea of what was core knowledge, what were the boundaries of what we needed to know. Textbooks were limited and did not necessarily relate to the course (except for *Grey's anatomy*).

Things started to look up at the end of third year. We began working in real wards with real doctors and patients. Being taught in small groups meant you became an individual again and could talk to tutors about any problems you were having. For the last three years of the course we worked in hospitals and were exposed to all the major disciplines and even a brief exposure to range of sub-specialities. There was a reasonably orderly coverage of everything, though there was still a good deal of uncertainty as to exactly what you needed to know. The evidence base for what we were taught was also questionable.

There was no remuneration for teaching, and there was a yawning chasm between good teachers and those who didn't take any interest. Bad ones were appalling. There were some excellent clinicians and excellent teachers, but they were not necessarily one and the same. There was no feedback given to either students or clinicians about their performance—a culture of critical enquiry had not been established. However, while teachers were of variable quality there were lots of them.

When we graduated few, if any of us, were fit for practice or fit for general practice registration. However, we received registration anyway. Most graduates felt they needed an internship.

Internship had no formal academic program; trainees were just thrown in to learn practical clinical skills as well as time management, how to manage the hospital systems, and so on. This was not bad for the student but probably not great for the patient. The interns were critical to the effective functioning of a hospital.

If they passed the exam after internship, many graduates went overseas to follow a subspeciality then returned to go into private consultant practice. However, as time went on budding physicians would instead acquire hospital posts in the speciality. The balance of generalism and specialism started to shift, and the training of the next generation fell more and more on these specialists.

Colleges in the 1970s and 80s started to be much more formal about postgraduate training. In the 1970s the Royal Australasian College of Physicians established a program for postgraduate training for the first time and this was handed over to the subspecialities.

Training has continued to increase in complexity and difficulty. Medical knowledge has advanced at an incredible rate—the armamentarium of treatment is enormous and the complexity of diagnosis and treatment have increased—therefore approaches have needed to become more systematic. At the same time, we have shorter patient times, more students, and less teaching hours.

Making sure that students gain the required knowledge, attitude and skills is challenging, and there is increasing recognition that supervisor training is needed, resulting in new approaches.

Some questions about the new challenges and approaches come to mind:

- Is the main emphasis going to be on capacity or quality—are we aiming to increase the numbers or improve the skills of supervisors?

- Are we in danger of over-engineering the process—will there be registration for supervisors?
- How do IMGs fit into the equation—what supervision is needed for them?
- Will supervisors continue to be active clinicians? (I think it would be a mistake to divorce the two processes.)

## Health Workforce Australia initiatives around clinical supervision

### Mr Mark Cormack, Chief Executive Officer, Health Workforce Australia

There has never been a time of greater pressure on Australian medical training. There has also never been a greater visibility and recognition of the importance of the medical workforce, highlighted by the publication of *Health Workforce 2025* and the policy responses to it. 'Workforce' used to be a small mention at Australian Health Ministers' Advisory Council (AHMAC) meetings; it now takes up half the meeting time. The importance of clinical supervision in producing that workforce is also being recognised.

HWA have been active in supporting clinical supervision through their Clinical Supervision Support Program. HWA have developed the National Clinical Supervision Support Framework (2010) to guide and support clinical education and training activity in the health sector. They have also recently released the draft National Clinical Supervision Competency Framework (2012), which details required competencies in supervision and potential assessment methods. A literature review around the quality of clinical placement has been done and will be published soon. HWA has also funded projects around the development of clinical placement assessment tools.

There are a number of issues and questions to be faced:

- There is a risk that clinical supervision becomes an industry in its own right—it needs to be part of the system, not a separate system.
- The commodification of clinical supervision through payment arrangements, incentives or industrial agreements runs the risk of clinical supervision being seen as not a core part of being a doctor part but an added extra. A further concern is that the cost of clinical supervision will become unsustainable.
- We need to raise standards in clinical supervision, but we don't want to disengage the clinicians who are doing it or make it too onerous in terms of bureaucracy or accreditation.
- All those involved in clinical supervision need to be open to innovation. For example, clinical simulation is an important addition to training and should be included in training and supervision regimes.
- AMC has a critical role in any training. We will need to work closely with them as the standard setter to ensure any developments in supervision or supervision training are aligned with the Australian accreditor.

## The impact of clinical supervision on health care quality and safety

**Professor Chris Baggoley, Chief Medical Officer, Australian Government Department of Health and Ageing**

Clinical supervision clearly affects the capacity of the system to train medical graduates. It is also important to look at the effect clinical supervision has on patient care. The Australian Commission on Safety and Quality in Health Care (ACSQHC) conducted a short literature review on the subject.

Firstly, surveys of residents found that:

- inadequate supervision was linked to negative ratings of learning, time with attendings and overall residency experience
- inadequate supervision was linked to negative features of training including medical errors, sleep deprivation, stress, conflict with other medical personnel, falsifying patient records, working while impaired.

[Baldwin D, Daugherty SD et al (2010). How residents view their clinical supervision: a re-analysis of classic national survey data. *J Grad Med Educ* 2(1):37-45.]

A recent paper found that close supervision of residents leads to fewer errors, lower patient mortality and improved quality of care (9 references).

[Tamuz M, Giardina T, et al (2011) Rethinking resident supervision to improve safety: from hierarchical to inter-professional models. *J Hosp Med* 6(8):448-465.]

The paper also showed that with a hierarchical approach to supervision, students were concerned that their questions could reflect poorly on themselves and they became embarrassed about mistaken decisions. With inter-professional supervision, nurses and pharmacists proactively monitored, intervened in, and guided residents' decisions, especially after hours, and were seen as non-judgemental. The paper also found that improving interpersonal communication (between supervisors and residents) can improve clinical outcomes.

There are of course a range of different activities that are all labelled 'supervision'. One paper identified four types of supervision:

- Routine oversight: clinical oversight activities that are planned in advance
- Responsive oversight: activities that occur in response to trainee or patient issues
- Direct patient care: where supervisor actively provides care for a trainee's patient
- Backstage oversight: activities of which the trainee is not directly aware.

The paper also identified the possible triggers for responsive oversight:

- Situation specific
  - Clinical cues: specific clinical issues that trigger the supervisor to provide increased oversight
  - Secondary source: influenced by someone outside the team
  - Language discrepancies: inaccuracies in terminology or clinical information provided by trainees

- General
  - Clinical cues: general clinical issues that provide a trigger, for example, a dying patient
  - Ability of trainee: supervisor's level of comfort with trainee's abilities.

[Kennedy T, Lingard L et al (2007). Clinical oversight: conceptualizing the relationship between supervision and safety. *J Gen Int Med* 22(8):1080–1085.]

Finally, it is worthwhile noting that supervision's role in protecting safety and quality in health care has been recognised for many centuries. In 1633, St Bartholomew's Hospital Regulations stated:

> That noe Chiurgian be suffered to p'forme the cures in this house by his boy or s'vant w'hout his own ov'sight or care.

## Independent Hospitals Pricing Authority and clinical supervision

### Ms Vanessa Vanderhoek, Executive Director, Policy Development, Independent Hospitals Pricing Authority

Activity-based funding has been a requirement of Australian Government hospital funding since 2008. The 2011 National Health Reform Agreement (NHRA) provided for the establishment of the Independent Hospital Pricing Authority (IHPA).

IHPA aims to deliver a national efficient price for activity-based funded public hospital services, including acute inpatients, emergency department services, and outpatient services. (From 1 July 2013, activity-based funding will also be introduced for sub-acute services.)

This funding is being gradually introduced: 2012–14 are transitionary years in which the total federal funding is limited to the level prescribed in the 2008 National Health Care Agreement. From 2014 onwards the Australian Government will be required to pay defined percentages of the growth in public hospital services; the government will contribute 45 per cent of hospital costs from 2014 and 50 per cent from 2017.

Under the NHRA, IHPA is also required to:

- determine the efficient cost of teaching, training and research (TTR) services from 1 July 2014
- provide advice to the Standing Council on Health (SCoH) on the feasibility of transitioning funding for TTR from a block grant to activity-based funding or another method that reflects activity volumes by no later than 30 June 2018.

However, there are no standard national definitions for teaching, training or research. In 2010, Health Outcomes International developed provisional definitions for teaching, training and research as part of a Department of Health and Ageing scoping study. Separate interim definitions have been adopted by the Australian Hospital Patient Costing Standards v2.0 for the purposes of costing. In the costing standards, training is not recognised as a separate product of hospital care.

IHPA is conducting research to decide how best to cost TTR, involving broad consultation with stakeholders. A number of projects will inform IHPA's advice to SCoH. Supervision is a key dimension that will be considered in this work.

Public hospitals report cost data for teaching and research through the National Hospital Cost Data Collection (NHCDC). States and territories have been requested to identify their 2012–13 teaching and research costs for NHCDC Round 17.

In 2012–13, jurisdictions entered bilateral agreements with the Australian Government regarding the proportion of federal funding that would be dedicated to TTR. TTR will continue to be block funded, pending outcomes of the work undertaken by with regards to pricing for TTR.

## Australian Medical Council standards in clinical supervision

### Professor Andrew Wilson, Australian Medical Council

The AMC works across all stages of education and training. There will soon be national standards for all phases of medical education and training, and all formal phases involve workplace-based training and education and require clinical supervision.

| Stage | Structure | AMC role |
|---|---|---|
| Basic / primary | 4–6 years university study, must include 2 years clinical experience<br>19 university medical schools | Accredits programs |
| Internship | 1 year of supervised practice in accredited posts/programs<br>State postgraduate medical councils accredit | Sets national standards |
| Vocational Postgraduate training | 3–7 years work-based training in supervised posts/programs<br>Multiple recognised specialties/fields of specialty practice in 16 specialist medical colleges | Accredits programs |
| Continuing professional development | Life long, mandatory for specialist registration<br>16 specialist medical colleges | Accredits programs |

Standards are rigorous and are at a high level, but AMC supports diversity, innovation and evolution in medical education. Accreditation standards can be met in diverse ways.

Standards are reviewed every five years, taking into account national policy, international and national developments and stakeholder feedback. Medical school standards were reviewed in 2011–12, and specialist medical programs standards are now being reviewed.

There are nine sets of accreditation standards (eight for medical schools):

- The context of education and training (including sub-standards dealing with clinical supervision)
- Organisational purpose and program outcomes

- The curriculum
- Teaching and learning methods (including sub-standards dealing with clinical supervision)
- Assessment of learning (including sub-standards dealing with clinical supervision)
- Monitoring and evaluation (including sub-standards dealing with clinical supervision)
- Trainee selection, support and appeals
- Educational resources, including supervision (including sub-standards dealing with clinical supervision)
- Continuing professional development (CPD).

The clinical education standards include those for medical schools:

> The medical education provider
>
> - ensures there is an effective system of clinical supervision to ensure safe involvement of students in clinical practice (new in 2013)
> - supports clinical supervisors through orientation and training, and monitors their performance (new in 2013)
> - works with healthcare facilities to ensure staff have time allocated for teaching within clinical service requirements (new in 2013)
> - has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the medical program and the responsibilities of the medical education provider to these practitioners.

And for specialist programs:

> The medical education provider
>
> - works with healthcare institutions to enable clinicians to contribute to high quality teaching and supervision, and to foster peer review and professional development
> - has defined the responsibilities of practitioners who contribute to program delivery and the provider's responsibilities to these practitioners
> - has clear impartial pathways for timely resolution of training-related disputes
> - has processes for selecting supervisors and assessors who have demonstrated appropriate capability for this role; it facilitates their training and professional development
> - routinely evaluates supervisor, trainer and assessor effectiveness including feedback from trainees.
>
> Training is practice based involving trainees' participation in relevant aspects of the health services and, for clinical specialties, patient care.
>
> The education provider provides feedback to supervisors of training on trainee performance, where appropriate.
>
> Supervisors and trainers' feedback is systematically sought, analysed and used as part of the monitoring process.

My own attitude is that it is important that we think about the changing medical practice environment we work in, which will have real impact on training changes. In particular, we can't forget that 70 per cent of medical practice now occurs in private practice—we will need to bear that in mind in any new systems we develop.

## Medical Council of New Zealand standards in clinical supervision

**Ms Joan Crawford, Medical Council of New Zealand**

The Medical Council of New Zealand (MCNZ) has a regulatory role across all stages of medical education. In New Zealand, supervision is required as a condition of registration for IMGs beginning practice and for interns in their first year of practice.

In looking at clinical supervision, MCNZ conducted surveys to find out what people wanted:

- Supervisors wanted
  - additional support and training
  - clearer guidance on what to do and how to do it.
- IMGs wanted
  - better orientation and induction
  - more feedback about performance
  - to know what was expected
  - time with their supervisors.
- Employers wanted
  - better understanding of interface of processes
  - thresholds for reporting poor performance.

This presentation is about the work we have done around the supervision of IMGs, which is transferable to general interns.

We have had three main achievements. First, we published *Orientation, induction and supervision for international medical graduates,* which is sent to each supervisor when they are appointed. It provides practical guidance on when and how to provide supervision and guidance, and concrete steps and tips about supervision. It is written in plain English and is a short booklet, so that supervisors can get some immediate information that will help them.

Second, we have provided clear guidance on the requirements for supervisors and employers.

Supervisor responsibilities are to:

- ensure orientation and induction is completed
- schedule regular protected time for supervision meetings
- provide feedback on performance and areas for improvement
- ensure alternative arrangements in case of absence
- establish clear lines of communication
- establish protocols for back-up help when necessary, for example on night duty
- ensure the IMG is able to work with the level of support available
- put in place more stringent systems and lower usual thresholds until familiar with IMG's work.

An employer or service may choose one of the following when employing an IMG:

- Individual supervision plan: MCNZ considers a proposed supervision plan as part of the registration process for an IMG

- Approved practice setting (APS): MCNZ accredits a service or practice for the purposes of employing and supervising IMGs.

Traditionally, an individual supervision plan was required every time an IMG applied for registration. With the APS we can accredit a service as a whole for a period of time. This is a more efficient process and encourages cross-site supervision and movement of IMGs between sites. A service accredited as an APS must demonstrate that appropriate support and supervision is available and provided to IMGs to ensure their safe integration into medical practice in New Zealand.

To be accepted as an APS, the organisation needs:

- effective clinical management of doctors
  - annual appraisal and credentialling
  - documented orientation and induction
  - framework for supervision
  - portfolios for each IMG
  - training for supervisors
  - relevant CPD for IMGs based on identified needs
- a system of clinical governance
  - organisational structure, quality management
  - clinical meetings
- regulatory assurance.

Finally, MCNZ have developed a framework for training for supervisors and implemented training workshops. The aim of the full-day workshop is for supervisors to:

- learn how to deal with cultural differences and different approaches to practising medicine
- gain an understanding of maps and models of supervision
- gain an understanding of a variety of supervision tools
- learn about different methods of providing feedback and dealing with difficult or poorly performing clinicians
- understand how to support an IMG to address gaps in performance
- gain an understanding of Council's processes and requirements for regulatory supervision of IMGs
- understand thresholds for reporting concerns.

MCNZ has held 16 training workshops since 2009 with almost 400 supervisors attending; 80 per cent rated the training as 'excellent' and 15 per cent rated it as 'very good'. Supervisors reported that they gained a useful understanding of different methods of dealing with cultural competence, communication issues, and performance concerns. They found that the workshops were an excellent forum to meet with other supervisors to network and share experiences, and wanted networking groups and online forums to be established to provide further support.

## Perspective of the clinical supervisor

### Professor Geoff Dobb, Federal Vice President, Australian Medical Association

There are many pressures on clinicians in public hospitals today—patient services for elective and unplanned admissions, administrative tasks, CPD, undergraduate teaching, and supervision for prevocational and vocational students. Effective clinicians also need to maintain a work–life balance, making time for themselves and their families. Clinicians are also subject to pressures from budget cutbacks, performance targets, and uncertainty about job security.

The numbers involved in supervision are changing. The number of students, prevocational and vocational trainees is rapidly increasing, while the number of supervisors and other staff assisting has not increased. This trend is only set to continue.

Supervision is also increasingly complex. We are not just supervising the development of technical skills, but protecting patient safety, and giving assessment, feedback and appraisal. We are also appraising not just clinical skills but also patient communication, time management, administration, and student teaching of other students.

More doctors are now supervisors, and more are needed. But it is important to remember that:

- supervision needs support
- supervision needs training
- supervision needs time, time, time.

Trainees rate time with their supervisor very highly. However, there is a lot of pressure on clinicians to meet patient targets, and thus to speed processes. The AMA guideline or target is that clinicians should spend 30 per cent of their time on activities other than patient care. However, this does not just cover supervision, but also administration, professional development, undergraduate teaching, leadership, and so on.

Time to be spent on supervision needs to be enshrined in industrial agreements and/or job descriptions. Currently very few clinicians have job descriptions, and the descriptions that exist are generally very broad.

The 2012 AMA Position Statement supports a range of strategies with regard to clinical supervision:

- Clinical support time for public hospital doctors
  - there must be time for duties not directly related to individual patient care
  - the overall benchmark for this time should be 30 per cent of employed time
  - this should be included in industrial agreements and job descriptions.
- Supervision and assessment of hospital based postgraduate medical trainees
  - the AMA supports the traditional apprenticeship model of training
  - quality supervision must be a high priority for the health system
  - directors of clinical training are essential
  - support from medical education officers is needed
  - key performance indicators (KPIs) are needed to support quality outcomes in clinical supervision and training
  - supervisors and trainees need to be clear about roles and responsibilities

- supervisors need training, including assessment and appraisal
- AMA supports the development of professional standards and competencies for clinical supervision.

Supervision needs resourcing, but the fundamental question is 'who will resource it?'. IHPA funding for TTR is currently 3.5–5 per cent of health expenditure, but I don't think there is a good understanding of the real burden of supervision within our health system—current funding cuts and emphasis on service delivery will probably expose it.

## Perspective of the trainee

### Dr Zoe Wainer, Surgical trainee

What does professional behaviour mean with regard to supervision?

Imagine you are a junior registrar, scalpel in your hand, in front of a patient with their chest open. I was screamed at by my supervisor to get out of the theatre.

Unfortunately, no one was surprised by such an outburst. While I have been told it is better than it used to be, such 'bullying' is still very much built in to the culture of supervision and traineeship in hospitals. Every student has a similar story to tell.

Why is medical workplace culture this way? The consultant doing the bullying was not a bad person or a bad medical practitioner. This was how his bosses treated him, and so this behaviour is repeated from medical generation to medical generation. There is almost a military culture, with an attitude that students need 'toughening up'. Current students are learning and repeating the behaviour both longitudinally and laterally within the unit. We need to break the cycle.

This is not just to do with improving the student experience: it is crucial to patient safety. If registrars, nurses and other members of the patient care team are being brought to tears in an operating theatre this has real implications for patient safety. Bullying also represents lost opportunities for effective supervision, communication and learning.

We know from a huge body of research that good learning environments are those where the trainee feels safe. We need to maximise every training opportunity—as has already been pointed out we have more and more trainees and fewer and fewer trainers. We can't afford to lose months of training opportunities through unsafe workplaces.

In a good ward round there were opportunities for discussion. The residents went round first and then went together with a supervisor. Good patient care was paramount, with each patient being seen twice. Residents were able to develop their own ideas, before checking them with a supervisor.

An interesting example of supervision in another industry is the recording of a plane incident that happening on a flight from Singapore. Four minutes into the flight one of the engines blew up, and 21 out of 22 safety systems failed. The reason the plane did not crash is that this workplace had a culture of listening to the most junior member, who in this case had noticed something crucial. Because this attitude was built in to the culture he was comfortable speaking up.

By contrast, junior members of a medical team are not encouraged to speak—indeed are actively discouraged from contributing. This again has real implications for patient safety and for their own learning.

Effective training, education and supervision are critical to the safety of patients and the welfare of junior doctors and should be at the heart of improving patient care and outcomes. Linking quality training to safe, quality health care must be the next paradigm.

## Panel discussion

### Payment for supervision

We need a sustainable business model for supervision and training to meet the needs of the increasing numbers of trainees. There is some work to show that current hospital payments cover only about one third of the training burden, so this is not sustainable. Goodwill from supervisors and their organisations is important, but we can't be solely dependent on it going forward.

IHPA's role is going to be critical in identifying funding to support supervision. The research IHPA is doing around the cost of supervision is not just based on estimates of costs provided by hospitals, but also on research into cost bases and information from other stakeholders and the public. The numbers are not taken at face value but are put into models to see what is sustainable. IHPA also needs to identify what can be classified and counted easily, so as not to add to the administrative burden of hospitals.

We are not necessarily talking about payment for individual supervisors, but about adequate support for the medical system as a whole so that there are enough staff to carry out all the different roles, including supervision.

In supervision there is a large contingent of 'heroic individuals' who enjoy the role. Many would be offended by being paid for teaching—they see it as part of their professional role and responsibility, which indeed it is.

Many also recognise the role supervision plays in their own learning—being with students keeps your own practice fresh. Knowledge definitely goes in two directions—learning is a continual process supported by being with students. Perhaps rather than payment we should be looking at supervision as a way of earning CPD points.

Supervision also needs to be included in industrial awards for doctors. This is the case in some states but there are disparities across the country. While supervision has been raised in the states where it is not included, it has been traded off against other wants. If doctors want support for supervision they will need to prioritise it. The medical profession needs to take responsibility for ensuring resources for appropriate supervision are included in enterprise bargaining agreements.

### Private settings

The need for supervisors is going to have to be solved, at least in part, by an effective use of private settings. The huge potential in private talent is a lost opportunity at the moment. However, harnessing this resource may require a broader rethink of how to fund training.

There is a lot of work being done in this area. IHPA and HWA are looking at existing funding models to look for opportunities for activity-based funding. We are seeing the introduction of placement fees in one of the area health services in New South Wales, and Victoria already has such a system in place. Some delegates were keen for this to be expanded, as long as it was made transparent and consistent for different services and professional groups. Some suggested that a two-tier approach to rebates may enable those private clinicians undertaking supervision to be appropriately rewarded.

### Quality and training

There is an urgent need for training in supervision. There is a need to equip supervisors so that bullying behaviour is reduced and effective supervision occurs. However supervisors often baulk at doing a training course, due to lack of time and lack of recognition. Many supervisors think they are already good at what they do. We need to approach this intelligently or we will lose the heroic individuals who are doing a good job.

Assessment could be used as a trigger for training. At the moment supervisors are not usually assessed by their students. This is commonplace in many other settings, for example 360 degree appraisals in industry, and student rating of university lecturers. Assessment should be a two-way street between students and supervisors.

We are not going to make every supervisor passionate, skilled and gifted, but we need to set up a system that supports a teaching and learning model. The New Zealand APS model does this by requiring training at an organisation level.

### KPIs

What KPIs are required? Should they be KPIs for individual supervisors or for the system as a whole?

Rather than setting KPIs, it is important to first build competency. [See *Quality and training* above.] Competencies can be built through training—in New Zealand as the number of supervisors who have been through the training increases, they are changing the way they do things and the way the system works.

For any KPIs, we need to make sure that we are not just measuring for the sake of measuring, but so that we can track and encourage improvement.

Simple KPIs to start with should be based around measuring:

- quantity: How much time is set aside by staff for supervision?
- quality: What proportion of your consultant staff have attended a course on clinical supervision? Currently we are required to track how many staff have attended fire safety training—surely supervisor training is more important!

## Clinical supervision support resources

## Health Education and Training Institute initiatives

### Dr Anthony Llewellyn, Health Education and Training Institute

Supervision is a broad-spectrum tool that can solve a lot of issues.

The Health Education and Training Institute first developed the *Superguide to Prevocational Training* in 2010, and this was rapidly adapted for other medical groups. For example, it is now being adapted for nursing, midwifery and oral health.

The principles of supervision, as described in the Superguide, are that supervision is:

- a relationship-based activity
- an active process
- an ideal forum to promote life-long learning and CPD.

The Superguide also says that a supervisor should be available and approachable.

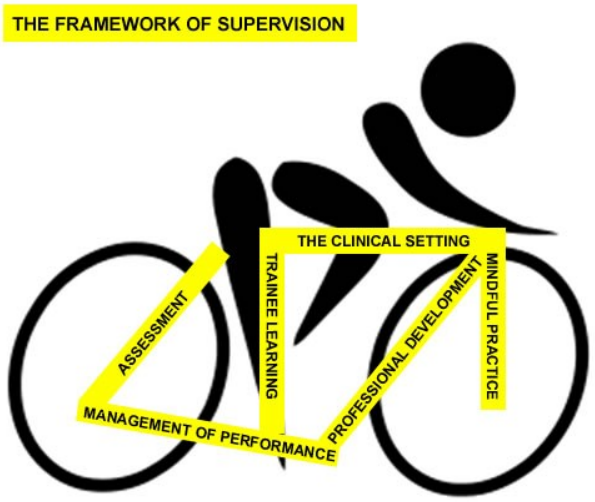
The Superguide is a practical guide that tells supervisors exactly what to do and gives them tips and links to resources. It aims to be user friendly for busy physicians, and to be applicable across the career spectrum. It includes:

- what is supervision
- how to be an effective supervisor
- clinical teaching and learning
- management of clinical staff.

## Clinical Supervision Support Project of MDANZ, CPMEC and CPMC

**Ms Andrea Lloyd, Educational Development Manager**

The project, supported by HWA, aims to promote best practice in clinical oversight and education supervision of medical students, prevocational and vocational trainees in clinical environments. The project has developed a framework for supervision, which both ensures patient safety and learning development for the trainee.




A training curriculum for supervisors is based around the entrustable professional activities of supervision (EPAs) which form the framework of supervision (www.clinicaleducators.org).

The project seeks to provide a range of focused interventions for clinical supervision (FICS):

- Self FICS: online learning
  - is intended as an introduction to fundamental, generic concepts for new supervisors or as a refresher of key concepts
  - comprises six modules covering the EPAs of supervision
  - provides a certificate of completion
  - has the potential to be utilised by supervisors from all programs.
- Group FICS: workshops
  - is intended to 'value-add' to online modules
  - supports the practice of supervisory skills such as the giving of and responding to feedback, challenging conversations
  - is provided for senior students and trainees through to specialist level with differing focus.
- Team FICS: unit intervention
  - recognises that clinicians do not work in isolation; workplace culture and support impact on one's ability to supervise
  - facilitates discussion between clinicians on individual units with the aim of refocusing on the role as a clinical teaching unit as well as one of clinical service.
  - examines current training practices; supports and barriers; potential for change; training required

# Discussion

## Outcome 1

### Chaired by Dr Lee Gruner and Professor Jane Dahlstrom

The aspects of clinical supervision that need to remain discipline and sub-discipline specific and those that are generic across the medical education and training continuum.

### What are the core generic competencies of clinical supervision?

There were many competencies that were identified as essential to supervision across disciplines and teaching levels. There was some discussion about what was a competency and what was a personality attribute, however it was felt that most of these competencies could be taught and improved. The identified competencies were:

- communication skills (including both written and verbal, and both talking and listening)
- emotional intelligence (approachability, rationality, calmness, flexibility)
- subject mastery of the relevant curriculum scope
- skills in giving constructive feedback
- skills in developing and managing performance
- understanding of learning principles
- teaching skills
- mentoring skills (which are different from teaching skills)
- understanding of the assessment process
- teaching effective teamwork within a multidisciplinary team
- cultural awareness and sensitivity
- leadership and being part of a learning culture within the organisation
- making a safe learning environment
- understanding of occupational health and safety.

### What are the discipline/sub-discipline specific competencies of clinical supervision?

The list of discipline-specific competencies was much shorter:

- context-specific knowledge and curriculum
- specific procedural and technical skills
- specific safety and quality measures and issues, for example in pathology
- acuity and risk profiling
- specific assessment processes.

**What are the common experiences of clinical supervisors across the various health care settings?**

- Bad experiences:
  - trainee difficult or underperforming
  - lack of time
  - undervalued
  - insufficient professional development for supervisors
  - bureaucracy
  - lack of resources and physical space
  - working in a hierarchy
  - not enough CPD
- Good experiences:
  - Teaching On The Run
  - appreciation from students and trainees
  - seeing trainees improve
  - 'fostering progress autonomy' of trainees
  - Recognition from those in more senior positions of the value of supervison

**Why do people become supervisors?**

Delegates felt it was useful to explore the drivers for supervision as an input to programs aimed at increasing supervisor numbers. The reasons they identified for people becoming supervisors were:

- personal satisfaction
- acknowledgement
- a desire to give back to the system
- intellectual stimulation
- learning from students
- protecting patients from adverse events
- expanding the referral base for the supervisor

## Outcome 2

**Chaired by Professor Paul Worley and Associate Professor Stephen Tobin**

The adequacy of the generic clinical supervision support resources that have been developed for use across medical education and training, how to address the gaps, and determining a process of sharing clinical supervision support resources across medical disciplines and the training continuum.

**How do we address the training and development needs of current and future clinical supervisors?**

We need to focus our efforts on the generations coming behind—not the current doctors who are not yet good supervisors. This means we need to foster the interest of current students. This could be achieved by making supervisor training part of all education and training

levels. This would improve skills and implant the idea that supervision is an integral part of clinical work. It could also start to change the bullying culture through early training.

Training for existing or emerging supervisors should be mandated, made part of institutional KPIs, or rewarded. It is critical that training courses for this group are made readily available. Student feedback for trainers can be an important part of the training process, both to trigger the need for training and to provide a measure of how training improves performance. Feedback needs to be specific, targeted and anonymous. Awards for good supervision, similar to university teaching awards, may strengthen the standing of supervision. We also need to bring rural supervisors in to training workshops, and/or provide online resources. Clinical supervision for IMGs may require specific additional skills or approaches.

Recommendations from delegates included:

- To HWA: Consider not funding additional 'teach the teacher initiatives'—the highest priority for support is to harmonise existing programs.
- To HWA: Consider funding the development of a marketing approach to motivate and recruit supervisors (including identifying motivators); and consider funding the development of processes to evaluate teaching and supervision skills, including student and trainee feedback.
- To CPMC: Include supervision training and activities as part of CPD points.
- To MDANZ and CPMC: Develop processes and guidelines about dealing with poorly performing trainees.
- To CPMEC, MDANZ and CPMC: focus efforts of supervisor training on junior consultants, registrars and students

**What are the pros and cons of creating a 'specialty society' for clinical supervisors?**

There is clearly value in linking and supporting clinicians to become supervisors. Delegates did not think a formal 'specialty society' should be created for supervisors, as all clinicians are potentially a supervisor and all should be involved in supervision in some capacity. The notion of a 'club' of supervisors was considered a better option, with an online forum and regular meetings, probably yearly, to help provide much-needed support and networking of ideas.

## Outcome 3

**Chaired by Dr Anthony Llewellyn and Associate Professor Alison Jones**

A cost-effective sustainable model to support and develop clinical supervisors and improve the quality and consistency of clinical supervision across the education and training continuum.

**What are the essential elements of a cost-effective sustainable supervision model?**

Delegates identified some key principles around supervision:

- Supervision must be recognised as an essential part of a quality health system.

- Supervision needs to be seen as core business by all parts of the system. At the moment different parts of the system have supervision at different points in their hierarchy.
- The fundamental importance of supervision is perhaps currently considered more important for the training organisations than for the health system. Given Q&S issues, supervision needs to be considered as of primary importance for health, not just the training organisations.
- The system should be funded so that clinicians can spend the time needed for effective supervision. While it will be difficult to 'unpick' tasks to develop an activity-based funding model, it will be important in order to fully demonstrate the burden of supervision and to provide adequate support.
- A business case for supervision—linking effective supervision to patient outcomes—will be important to elicit full support for supervision from employers.
- Supervision needs to be recognised as part of professional development and to earn CPD points.
- There should be KPIs for supervision embedded right across the health system.

• Supervision capacity needs to be expanded and incentives created.
  - The burden of supervision is on a few people—we need to get more clinicians involved to share the load.
  - Expectations and incentives for supervision need to be built into the system and supported at individual, organisation and system levels. It should be recognised that incentives are not just financial—while differential pay scales or rebates may be appropriate, other forms of incentive such as organisational recognition, improved career path and awards may be sufficient.
  - The development of adequate supervision resources is a progressive process—it is more important to make sure students are being trained in supervision and are expecting to supervise than to try to make everyone who is already in practice into a supervisor. Supervision training needs to start early and continue at every level. For example, we should trust junior doctors to be supervisors earlier than when they become consultants.
  - We also need to develop supervisors at every level. Supervisors can act latitudinally across the healthcare team, not just in the normal longitudinal approach.
  - Whatever model is developed should not depend on new resources. While some may disagree with the principle, the reality is that new resources are not going to be forthcoming.
  - We need to use existing resources more efficiently, especially private practices. We need to unlock the potential for supervision in other settings.
  - It is also important to recognise that medical practice is changing and activity in private settings is growing. Thus we need to use private settings not just to meet supervision needs, but to ensure students get the full range of experiences they need to practice medicine. For example, bariatric surgery is one of the fastest growing areas of surgery, but is almost exclusively done in private practice. Thus interns will only learn about it in private practice.
  - In using private settings, we need to capture the good bits of the apprenticeship model. In particular, we need to ensure private practitioners can have a student for a reasonable length of time so that they can develop a relationship with them and take them through processes. This is useful both for the clinician and the student.
  - Models of supervision should not be based on large metropolitan teaching hospitals, as there are many other settings to take into account. We need underlying principles

that are applicable across various contexts so that we can embrace and support expanded settings.

- Training and feedback are important
  - Training is very important for supervisors and there are many resources being developed. KPIs or mandatory requirements will be needed to improve training levels, however the business case must be made first.
  - Performance reviews for clinicians would help to drive increased involvement in supervision and increased training levels. We 'fail to fail'—it can be difficult to provide feedback to poorly performing supervisors, thus a formal system needs to be established.
  - Feedback from students should be built in to supervision processes.

**Should annual meetings be held around clinical supervision?**

Annual meetings could be valuable to develop partnerships and foster learning. They would also be an opportunity to showcase existing resources and programs, so these become used more widely. We also don't have a structured way to reach consensus between jurisdictions or organisations on policy, approaches or recommendations. Such meetings or other networks may help. It would be important for meetings to involve everybody, not just those who are already interested and converted. A social media approach at meetings or instead of meetings might engage a broader range of people. The meeting could be a dedicated separate event or it could be part of another relevant event.

Other ways of networking and making connections should also be explored, for example online websites or forums to develop a 'community of practice'. The National Medical Training Advisory Network (NMTAN) may be a place to start.

**How do we promote safety and quality through a skilled supervisory workforce?**

A national safety and quality standard with regard to supervision could be developed by ACSQHC. Research around this issue is critical, as is the measurement of outcomes. We need to be able to correlate patient outcomes with supervisory practices (measured through organisation KPIs and through student feedback) and supervisory training. This will allow the development of models of effective supervision.

**What is the impact of AMC standards on supervisory training and provision of a supervisory workforce?**

AMC standards are very important because they provide authority for those involved in supervision and in developing programs around supervision. The standards provide a lever to start discussions about supervision within organisations and to get supervision included in business models, since supervision is recognised as not just being 'a good thing', but essential to accreditation. The strength of AMC standards goes across jurisdictions and across silos.

AMC standards could go further, for example requiring all supervisors to be trained or requiring organisations to get student feedback on supervision. However, standards need to be balanced with the need for supervision capacity—we don't want to restrict quantity to get a particular level of quality.

### How do we promote innovation and reform in clinical supervision?

We need to look ahead to solve the problems in the next generation. One important approach will be to have explicit supervision courses and practice as part of undergraduate training and at all levels of the curriculum. This will help to develop effective supervisors, reduce bullying, and convey the expectation that teaching is part of a professional career.

There is a considerable level of innovation already taking place. Various programs and resources have been developed—both by individual hospitals and by larger agencies—but they are not being effectively rolled out and are not reaching the supervisors and organisations in need. People find it difficult to find information [see *Annual meetings* above]. We need to identify and map what has been done to date and to make sure it is easily accessible.

A range of agencies and forums could help to drive change: HWA, NMTAN, AMA Doctors in Training Committee, junior medical officer forums.

A system to recognise and reward supervision would be helpful. For example, university teaching awards have been very successful in raising the profile and standing of teaching (as opposed to the traditional approach of only recognising research).

It is important to recognise that our problem is not unique and planning for the next generation of workers happens in lots of industries. Therefore we can learn from them. We should look outside the medical system for tools and processes that could help, instead of reinventing them.

### What is the data development and research needed around supervision?

The data and research that are needed are in five main areas:

- Capacity: Research is needed to see how different models and types of supervision could unlock supervision capacity to support the growing number of students. We particularly need to explore how private settings can be drawn into the supervision system. We also need to know exactly what capacity is needed—how many supervisors at what level—for the number of students coming through the system. These ratios could be used as guidelines for employers.
- Safety and quality: The correlation of supervision practices, training and organisational approaches with safety and quality measures will be important to the development of effective supervision models and standards. Supervision is not yet recognised within National Health Priority Areas.
- Training: KPIs in training would provide a measure and driver for training within organisations. We also need to be able to correlate training in supervision with student feedback and with safety and quality. Should training be a KPI or should training be made a prerequisite for supervision? Many training courses are mandatory within the health care system—for example fire and occupational health and safety—so it would make sense to mandate this important area.
- Feedback: Feedback from students will be important to trigger supervisor training and improvement, to inform training models, and to correlate to safety and quality measures and thus inform future supervision practices. Feedback should be standardised and

anonymous. Transparent assessments at an individual level would feed into the organisational level and contribute to accreditation.

- Organisational KPis: KPis are needed to measure improvement and allow correlations to be made between various aspects of supervision, student experience, and patient care and outcomes. Publication of peer comparisons around supervision could be valuable.

# Appendixes

## Summit program committee

Sharyn Cody
Joan Crawford
Jane Dahlstrom
Kevin Forsyth (Chair)
Lee Gruner
Alison Jones Steve
Kozel Anthony
Llewellyn
Mel Miller (Facilitator)
Andrew Singer
Jag Singh
Mary Solomon
Paul Worley

## Summit attendees

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| Dr Glenda Battersby | Director, Clinical and GP Training | Lyell McEwin Health Service |
| Ms Marece Bentley | Secretariat, Coordinator | PMCWA |
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