

# The Superguide:

A handbook for supervising doctors

June 2013  
SECOND EDITION  
HETI | RESOURCE



Health





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# How to use this interactive pdf

This version of the Superguide has been set up to let you find what you need quickly. Here are a few tips to help you get the most out of it.

**The document is fully searchable**, so if you are looking for a particular topic, you can press CTRL and F or click Edit and Find to search for a word or phrase.

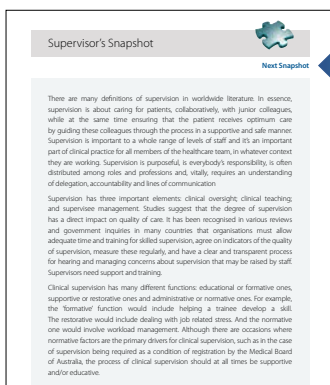


All links logos and are live so you can click these to find more information

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# Foreword

To supervise literally means to watch over another individual, with the aim of enhancing that individual's performance and to ensure the delivery of quality care to patients. In the medical profession, supervision takes on a deeper meaning – it has been used throughout history to pass on learning and develop clinical skills and more importantly, to explore and define what it means to be a doctor.

Medical professionals need quality clinical supervision to deliver excellent patient care. At every stage of their careers, doctors either receive or provide clinical supervision. In a world that has seen dramatic changes in the demand for health care and in the way health care is delivered, supervision still holds a crucial place in preparing doctors for the challenges they will face.

Because people learn largely from their interaction with colleagues, there will always be a need for quality supervision. Significant advances have been made, however, in the evidence base that underpins our role as clinical supervisors.

Over the last century, there has been a shift towards the model of competency, a shift that challenges the traditional modes of medical education and has as its aim the development of doctors who are great clinicians, effective team players and who take a patient centred approach to medicine.

It is crucial for clinical supervisors to keep up to date with and adapt to these changes to ensure that the best possible care is provided to supervisees and, ultimately, to our patients.

With this in mind, I am glad to introduce the second edition of The Superguide: a guide for supervising doctors. This resource was developed with the help of medical professionals throughout NSW, in partnership with HETI through the funding assistance extended by Health Workforce Australia's Clinical Supervision Support Program.

It is my hope that this document will provide current, practical and relevant information that you can apply as you watch over and share your learning with the next generation of doctors.

On behalf of HETI, I would like to take this opportunity to thank all clinical supervisors for your commitment to excellent health care delivery and the development of the medical profession.



Heather Gray  
Chief Executive  
Health Education and Training Institute

# Acknowledgements

The revised edition of the Superguide was developed on behalf of HETI by Professor Brian Jolly and Conjoint Professor Jane Conway and their team from the University of Newcastle. It was adapted from 'The Superguide – a handbook for supervising doctors in training', 1st edition, November 2010 written by Craig Bingham and Dr Roslyn Crampton.

The revised Superguide has also drawn from 'The Superguide – a handbook for supervising Allied Health Professionals', 2nd edition, April 2012, written by the Superguide Steering Committee and 'The Superguide – a guide for supervising Oral Health Professionals' written by Endeavour Training and Development Limited and the Oral Health Superguide Working Group.

We would like to acknowledge all of the doctors who played a role in developing this guide through reviews, case studies and contributions.

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This project was made possible due to funding made available by Health Workforce Australia

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# Introduction

Why am I **passionate** about supervision?

## **Supervision is rewarding.**

Numerous studies have noted the impact of quality supervision on the trainee experience with trainees rating the quality of the supervisor or supervision as either the most important or one of the most important factors in their clinical learning experience (Siggins Miller, Health Workforce Australia Quality of Clinical Placements Review, 2012).

## **Supervision makes a difference to people's lives.**

Putting it simply, supervision improves health outcomes and safety.

I truly believe that by investing in quality teaching and training, we improve the delivery of care and the evidence once again backs up this assertion. In the April 2012 issue of Academic Medicine in, Jeanne Farnan and others conducted a systematic review of the effect of clinical supervision on patient outcomes and after reviewing 24 individual articles, they concluded that:

Enhanced clinical supervision of trainees has been associated with improved patient- and education-related outcomes in published studies.

## **Supervision is fun and supervision is good for your soul.**

Supervision is not only good for the supervisee; it is good for the supervisor. Supervision keeps you on your feet, encourages you to stay up to date in your knowledge and, in those dark moments when we might just allow ourselves to believe reports that the healthcare system is getting worse, it is the act of supervision - the passing on of the knowledge and wisdom of medical care to the next generation - that is the spark that reminds us that it still matters, that there is a point.

What excites me most about being a supervisor goes beyond just being able to impart knowledge and wisdom. Rather, it is the opportunity to affect and empower the attitudes of trainees. In a study in 2006, Kua and others reported that the two highest ranking attributes medical students used in describing an effective medical teacher were "passionate about teaching" and "motivates and inspires the students".

I have a passion for supervision. I'm also passionate about ensuring that doctors in NSW Health not only have the knowledge and skills to deliver care but also have an appreciation of the NSW Health values of Collaboration, Openness, Respect and Empowerment.

This means that doctors understand that health care is a team activity and that patients and families don't just want us to give them care, they also need to feel that we actually care.

This is the second edition of the HETI Medical Superguide. In this edition, we have departed from the emphasis on prevocational medical doctors (interns and residents) and broadened the guide's scope to supervision for the full range of the medical practice continuum.

We took this approach to respond to feedback on how the previous JMO Superguide was being used in the workplace in NSW. We received reports that supervisors found the guide as a practical tool for dealing with trainees in every level and that specific sections of the guide, such as the ones on giving feedback and to dealing with a JMO in difficulty, filled an important gap in the supervisor toolkit.

In addition, the broader scope of the Medical Superguide is in response to increasing evidence that many areas, approaches and techniques are used in clinical supervision within medicine and in other health disciplines.

The fact is that we are now training, working and supervising teams of health professionals and we need to simplify and clarify what we expect from clinical supervisors.

Why should there be such a huge difference or expectation for a Psychiatrist who supervises medical students, interns, trainees in one instance and the occasional nurse, psychologist and social worker, in the other?

This new HETI Medical Superguide complements a number of similar publications - the Allied Health Superguide, the Oral Health Superguide and soon the Nursing and Midwifery Superguide.

All these publication aim to ensure that supervision is recognised as an important relationship in the health service between senior and junior clinician, and is supported by the health service. More important, the goal of the HETI Superguides is to help supervisors deliver: safe and quality patient care through performance monitoring; increased learning and knowledge; and the welfare of the junior clinician.

I hope that this Superguide makes you more passionate about supervising too.



Dr Anthony Llewellyn  
Medical Director  
Health Education and Training Authority



# The SuperSummary:

## Supervising doctors at the point of care

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### Supervision is part of good medical practice

- Constructive feedback is one of the most valuable aspects of the supervisory relationship
- Contributing to the professional development of junior doctors can be one of the most rewarding aspects of a senior clinician's job

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### Patient safety comes first

- Supervision is part of clinical governance
- The whole healthcare team is involved in maintaining patient safety. The quality of supervision makes a difference to the quality of patient care

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### Supervision can be delegated but never abdicated

- Robust supervision necessitates clinical oversight, which provides opportunity for clinical teaching
- Clinical supervision is a worthwhile investment of time as it reduces errors and creates more competent and independent supervisees
- Sound supervision keeps the supervisee and patient safe and well by actively monitoring the supervisee's level of stress and ability to cope

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### Supervision is active

Active supervision acknowledges that some junior clinicians, or all clinicians in some situations, are “unconsciously incompetent” – that is, they do not know what they do not know, and will not always recognise situations which are beyond their current abilities. Active supervision requires that the supervisor is sufficiently engaged and vigilant to support supervisees when they need assistance, whether or not a request for assistance is made. It is not sufficient to wait for the supervisee to seek assistance. The supervisor must:

- actively engage in identifying the supervisee's current level of ability and function
- anticipate potential problems
- be proactive in finding solutions

---

### Objectives of clinical supervision

- Safe and quality patient care and treatment
  - Supervisee learning
  - Supervisee and supervisor development
  - Clinical team building
  - Supervisee welfare
-

# The SuperSummary:

## Supervising doctors at the point of care (continued)

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### The attributes of an effective clinical supervisor

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

An effective supervisor has specific personal attributes, clinical skills and teaching skills. In particular, the supervisor is able to exercise judgement in when to be “hands-on” or “hands-off” and give constructive feedback and in some cases, provide mentorship about the future career plans of the supervisee.

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### As effective clinical teachers, clinical supervisors should

- Collaborate and interact with supervisees and other staff members to assess the clinical, communication and professional skills of supervisees and provide them with formal and informal appraisals
  - Relate learning to the current clinical duties of the supervisee
  - Target the learning needs of the supervisee
  - Use the Socratic method: asking and encouraging thinking
  - Set clear goals: Clear goals are SMART: Specific, Measurable, Attainable, Realistic and Timely
  - Give and seek feedback
- 

### “Hands-off” supervision is not absence of supervision

#### **The medical care of the patient is the responsibility of the senior clinician.**

This is not a responsibility that can be delegated. The senior clinician is responsible for supervising the work of supervisees caring for patients. This means (at a minimum) that the senior clinician:

- discusses the management plan for the patient with doctors acting under the senior clinician’s instructions to ensure their understanding of the care required
  - routinely oversees patient care to ensure that junior clinicians are performing competently
  - is vigilant to detect triggers for further supervisor involvement in care
  - is accessible when junior clinicians call for assistance or guidance
  - clearly communicates about when to contact the senior clinician
  - recognises that junior clinicians tend not to recognise the severity of illness
-

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**Teaching procedural skills: A process**

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

**Being a term supervisor**

The ultimate responsibility for assessing trainees and managing their welfare remains with the term supervisor.

**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. Senior clinicians are encouraged to delegate supervisory responsibilities to registrars, develop their performance as clinical supervisors and provide supervision and feedback. Seek their opinion as part of assessing others who you supervise, but do not substitute their opinion for an exercise of your own judgement.

**Handover and clinical supervision**

Senior clinicians should be present at handover to guide the process and ensure handover is comprehensive and accurate. Senior clinician presence at handover, followed by clinical teaching, improves patient care, builds the skills of junior medical staff and reduces the need to call consultants back.

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Teaching in the presence of patients is where theoretical knowledge is applied in practice in the presence of patients. Contributing to supervisee learning is enjoyed by most patients and considered by supervisees to be the most effective way to learn clinical care and skills.

# Introduction:

## The scope, purpose and function of supervision

### Supervisor's Snapshot



There are many definitions of supervision in worldwide literature. In essence, supervision is about caring for patients, collaboratively, with junior colleagues, while at the same time ensuring that the patient receives optimum care by guiding these colleagues through the process in a supportive and safe manner. Supervision is important to a whole range of levels of staff and it's an important part of clinical practice for all members of the healthcare team, in whatever context they are working. Supervision is purposeful, is everybody's responsibility, is often distributed among roles and professions and, vitally, requires an understanding of delegation, accountability and lines of communication

Supervision has three important elements: clinical oversight; clinical teaching; and supervisee management. Studies suggest that the degree of supervision has a direct impact on quality of care. It has been recognised in various reviews and government inquiries in many countries that organisations must allow adequate time and training for skilled supervision, agree on indicators of the quality of supervision, measure these regularly, and have a clear and transparent process for hearing and managing concerns about supervision that may be raised by staff. Supervisors need support and training.

Clinical supervision has many different functions: educational or formative ones, supportive or restorative ones and administrative or normative ones. For example, the 'formative' function would include helping a trainee develop a skill. The restorative would include dealing with job related stress. And the normative one would involve workload management. Although there are occasions where normative factors are the primary drivers for clinical supervision, such as in the case of supervision being required as a condition of registration by the Medical Board of Australia, the process of clinical supervision should at all times be supportive and/or educative.

# Beyond Basics:

## The scope and purpose of supervision

Teaching, supervising and assessing are recognised as core elements of good medical practice (Australian Medical Council, 2009). In the context of clinical practice,

*Supervision is a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client (patient) practitioner relationships and the wider systemic context, and by so doing improves the quality of their work, transforms their client (patient) relationships, continuously develops themselves, their practice and the wider profession. (Owen & Shohet, 2012).*

According to Tay, Sanger and Llewellyn (2008),

*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.*

Clinical supervision is important for:

- Undergraduate students
- Interns
- Resident Medical Officers
- Registrars
- Career Medical Officers
- International Medical Graduates
- Clinicians returning to practice after extended breaks
- Clinicians moving from overseas
- Those moving into new and unfamiliar areas of practice
- Staff new to particular procedures or techniques

In short, clinical supervision is an essential part of every medical professional's working life. The variable factors in clinical supervision are the extent to which it is formalised; the focus of the supervision (i.e. whether it is directed to education, professional support or assuring compliance with standards for quality assurance); the clinical setting (e.g. whether it is in a general practice, a hospital and whether it is urban, rural or remote); and the nature of the work being undertaken by doctors in a given practice context. Clinical supervision is a complex activity. It is much more than coordinating experiences or providing clinical teaching. The function of clinical supervisors include:

- Manager
- Observer
- Instructor
- Assessor
- Feedback giver
- Counsellor

(Rose & Best, 2004)

For this *Superguide*, clinical supervision has been identified as having three key elements:

- **Clinical oversight** to lead, guide and support the supervisee at the point of care to ensure patient safety
- **Clinical teaching** to enable supervisees to develop the competence and knowledge required for responsible practice
- **Supervisee management** to ensure that supervisees are safe and well in their work

There is evidence that clinical supervision reduces errors and improves patient care and educational outcomes, and that inadequate supervision is a contributing factor in critical incidents with poor patient outcomes (Clinical Excellence Commission, 2010; Farnan et al., 2012., Kilminster et al., 2007). Hore et al., (2009) suggest that unsupervised experience may lead registrars and other junior staff to accept lower standards of care. 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.

The responsibility for clinical supervision is the same whether in the general practice, at the patient's bedside, on a ward round, or on the telephone to the supervisee. When writing about supervision in the NSW Public Hospital System, the authors of the Supervision for Safety Draft Discussion Paper (NSW Department of Health, 2010a) cite the work of Kennedy et al. (2007) to note:

*In reviewing supervision the significant leadership and legally defined role of the Attending Medical Officer (AMO) in having the primary responsibility for the patient during admission is critical. This medical officer is a consultant who may hold appointment as a visiting medical officer, honorary or staff specialist. The AMO may lead a team that includes related medical staff and this team plays a critical role in the clinical review and care of the patient. When allowing care of their patients by junior clinicians, the Attending Medical Officer is not able to relinquish their rights or responsibilities. Commissioner Peter Garling highlighted this role in his final report.*

*'...supervision involves more than the mere presence of senior medical staff on the same roster as junior doctors ... more than simply communicating with a junior doctor about a patient's diagnosis and treatment plan. It requires something more, being direct involvement in the patient's care and oversight' (Kennedy et al., 2007). While junior medical officers complete the notes, the AMO remains responsible and professionally accountable for the care of the patient.*

While a supervisee will have a nominated individual accountable for his/ her supervision, supervision is an integral part of health care. Elements of supervision of doctors are provided by all members of the health care team including those in other professions. Unfortunately, many resources fail to acknowledge that supervision is no longer one supervisor to one supervisee (if it ever was) and that there are several mechanisms of supervision:

- One to one
- Group – one supervisor
- One supervisee – group of supervisors
- Group of supervisees – group of supervisors

Supervisors supervise many different staff either directly or as part of their supervisory system. Supervisees may experience many different supervisors and are seeking consistency in supervision. However it is defined and implemented, clinical supervision is:

- Purposeful
- Everybody's responsibility
- Frequently distributed among roles and professions
- Requires an understanding of delegation, accountability and lines of communication

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. Clinical supervisors are not meant to perform their role without support. Responsibility for supervision rests with the whole organisation. Kilminster et al. (2007) concluded:

*There is strong evidence that, whilst supervision is considered to be both important and effective, practice is highly variable. In some cases, there is inadequate coverage and frequency of supervision activities. There is particular concern about lack of supervision for emergency and 'out of hours work', failure to formally address under-performance, lack of commitment to supervision and finding sufficient time for supervision. There is a need for an effective system to address both poor performance and inadequate supervision.*

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.

As Gough, Bullen and Donath (2010) point out, 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

# Beyond Basics:

## Functions of clinical supervision

Supervision comprises a number of different functions. Kadushin's model of supervision outlined three functions: educational, supportive and administrative (Kadushin 1976). These functions have been further defined by Proctor (1987) as formative, restorative and normative, describing them in terms of an interactive framework for clinical supervision, suggesting that all three functions should be overlapping and flexible (Driscoll 2007).

### Function

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#### Educational (Formative)

- Educational development of each doctor in a manner that enhances their full potential. It focuses on:
    - developing knowledge and skills
    - developing self-awareness
    - reflecting on practice
    - integrating theory into practice
    - facilitating professional reasoning
- 

#### Supportive (Restorative)

- Maintenance of harmonious and productive working relationships with a focus on morale and job satisfaction. It focuses on:
    - dealing with job-related stress
    - sustaining the morale of doctors
    - developing of a sense of professional self-worth
- 

#### Administrative (Normative)

- The promotion and maintenance of good standards of practice, including ethical practice, accountability measures and adhering to policies of administration. It focuses on:
    - clarification of roles and responsibilities
    - work load management
    - review and assessment of work
    - addressing organisation and practice issues
-



# Clinical supervision and clinical governance



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### Clinical supervision, clinical governance and vigilance

Clinical supervision is part of clinical governance and shares its target of ensuring patient safety. Not surprisingly, principles of effective clinical governance are also the principles of good supervision such as openness, learning, accountability, fairness and teamwork. The relationship and communication between supervisor and supervisee is critical. Supervision is at its most potent when it is an active process; when supervisors are engaged and vigilant in supporting supervisees, continually seeking cues as to the supervisee's performance.

This vigilance can be at various levels from routine oversight to what is called 'backstage' oversight – when the supervisor ensures care is progressing appropriately by checking the trainee's decisions, and enrolling other members of the clinical team to help supervise in their absence. Case studies or critical incident analysis is a useful way of mapping out how supervision has been inadequate or can be improved. Regular and active vigilance can be relatively easy to install, e.g.

- Have regular times to call supervisees out of hours (e.g. at 10:30 pm to check in)
- Have an agreed list of things that supervisees should call about (e.g. I always want you to call me if X occurs)
- Ask probing questions and seek factual information as supervisees usually underestimate the severity of an illness

# Beyond Basics:

## Clinical supervision, clinical governance and vigilance

### Patient safety comes first

Clinical supervision is essentially a component of clinical governance.

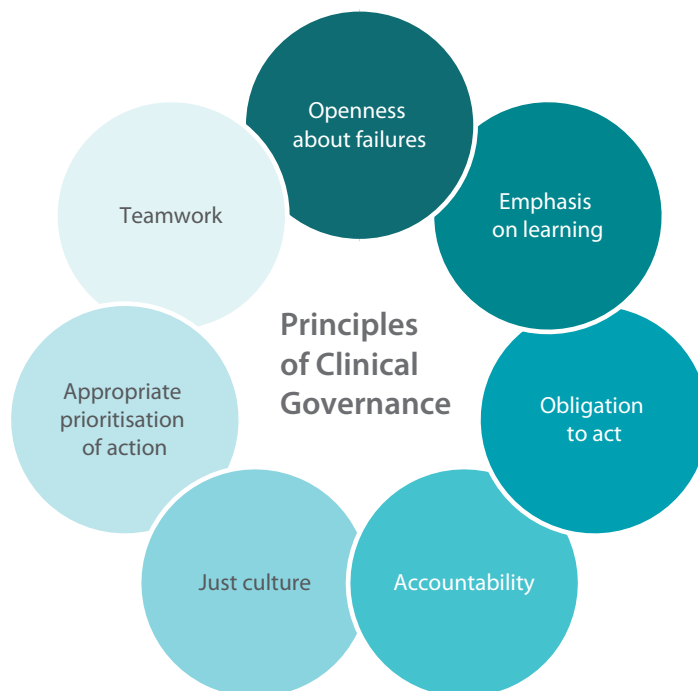
*Clinical governance is a framework through which (health) organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.*

(Sally & Donaldson, 1998).

The safety of the patient is the responsibility of the senior clinician. This is not a responsibility that can be delegated. The senior clinician is responsible for supervising the work of supervisees caring for their patients. This means (at a minimum) that the senior clinician:

- makes clear the criteria and process for escalation of a clinical situation
- has a relationship with the supervisee that does not impede communication or matters of concern
- uses a systematic and comprehensive process for handover of patient care
- ensures it is clear to the patient, family and colleagues who is responsible for the care of the patient

The guiding principles of clinical governance are the overarching principles of clinical supervision. This diagram shows the link between clinical governance and clinical supervision.



(Adapted from NSW Department of Health, 2005).

An important mechanism for ensuring the integrity of clinical supervision and governance is establishing clear criteria for supervisees to notify supervisors.

The SUPERB/SAFETY model is a bidirectional model for clinical supervision which identifies behaviours for those both providing and seeking supervision to reflect the dynamic situation of the supervisory relationship in clinical care (Farnan et al., 2010). Derived from research about internal medicine registrars in the United States of America, the model indicates the responsibilities of clinical supervisors (attending) in responding to residents and criteria for residents to notify supervisors.

## SUPERB/SAFETY model

Attending	Resident
<b>S</b> Set expectations for notification	<b>S</b> Seek attending input early
<b>U</b> Address uncertainty	<b>A</b> Active clinical decisions
<b>P</b> Planned communication	<b>F</b> Feel uncertain about clinical decisions
<b>E</b> Easy availability	<b>E</b> End-of-life care discussions
<b>R</b> Reassure fears	<b>T</b> Transitions of care
<b>B</b> Balance supervision and autonomy for resident	<b>Y</b> Help with the system hierarchy



### Active vs passive 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 having difficulty with mobilising post-procedure as she is too dizzy and weak to attempt standing.

#### 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 sends the advanced trainee to the rooms ahead of him and, 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 has postural hypotension, slow pulse rate and rising creatinine and potassium. 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. Antihypertensives, ACE inhibitor and NSAIDs are ceased.

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.

The consultant meets with the intern away from the patient and other staff and asks her to think about what has occurred. The consultant reassures the intern that he and others in the team are responsible for the patient’s overall care but there are key factors he would like the intern to think about.

The consultant carefully keeps his tone conversational and reinforces to the intern that her knowledge was satisfactory and shares that he has also had experiences where he has been caught up in other things. He tells the intern that he sets an alarm on his mobile phone for time critical things and suggests she does the same in future.

Path one exemplifies inadequate and ineffective 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 effective supervision: the consultant is an active, not passive, supervisor; he identifies and addresses the unconscious incompetency 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 care. He provides constructive feedback to the intern and suggests ways to improve performance.



# Developing Registrars and Career Medical Officers (CMOs) to be Clinical Supervisors

## Supervisor's Snapshot



### Developing Registrars and CMOs to be Clinical Supervisors

When registrars and CMOs supervise, they usually do so with junior medical staff who may be under stress from sources such as the loss of their structured learning environments as recent students and increased levels of responsibility. The relative informality of the supervision provided by registrars is highly valued by junior doctors. Registrars are more like mentors than managers. CMOs usually have intimate knowledge of the hospital and its people, so may have particular value as supervisors. However both may require some preparation for these roles. CMOs, registrars and supervisees also need to be aware of the differences between clinical supervision and line management. Both supervision and effective management are essential to support clinicians and do overlap. However, there are some differences in the skill sets. For example, line managers work on and with the system, supervisors generally work with the personnel

# Beyond Basics: Developing Registrars and CMOs to be Clinical Supervisors

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

Junior Medical Officers (JMOs) report that most hands-on supervision is provided by registrars, who also provide much of their effective clinical teaching. All involved in clinical supervision of JMOs should be aware that the transition from university student to prevocational trainee can be stressful. 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 (Markwell & Wainer, 2009). Contributing factors to this difficulty include:

- 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

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/CMO	For the senior clinician
<ul style="list-style-type: none"><li>• Your role in supervision and teaching is highly valued. Enjoy it.</li><li>• Supervise junior doctors with the understanding that you would like your supervisors to show you.</li><li>• 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.</li><li>• 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'.</li><li>• Take advantage of the Teaching on the Run program to learn skills that will be valuable throughout your clinical career.</li></ul>	<ul style="list-style-type: none"><li>• Developing supervisory skills is an important part of registrar training. Delegate supervisory responsibilities to registrars, assess their performance and provide training and feedback.</li><li>• 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).</li><li>• The ultimate responsibility for assessing trainees and managing their welfare remains with the term supervisor.</li><li>• 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.</li></ul>

## Clinical supervision and operational management: distinct but interrelated processes

Both supervision and effective staff management are essential to support clinicians. Whilst they can be seen as separate processes they are complementary and must coexist. Operational management is frequently required to support clinical supervision processes in practice. Operational supervision is provided by line managers who have clear accountabilities and responsibilities for the day-to-day management of workplace practices and service delivery. Operational supervision includes planning and monitoring workload and ensuring workplace health and safety and performance appraisal and management.

Operational managers may also become aware of issues that require medical staff be offered a form of clinical supervision. Medical staff who are operational managers also frequently participate in clinical supervision as both supervisor and supervisee. Operational managers and clinical supervisors have a shared responsibility to monitor and assess supervisees' performance and ensure adequate orientation and training.

Some differing functions of line managers and clinical supervisors

Line management supervisors	Clinical supervisors
Human resource management (e.g. attendance, leave, disputes, performance)	Facilitate knowledge and skills acquisition, engage in reflective practice, ensure service delivery is following best practice standards
Budgeting and resource management	Educating (teaching, facilitating, conceptualising about professional issues, evidence based intervention and best practice)
Change management	Supporting, evaluating, promoting and maintaining individuals in the workplace
Allocating work	Assisting individuals and groups to be productive in the workplace through listening, understanding and reflecting
Approving clinical supervision arrangements	Actively engaging in supervision arrangements as supervisors and supervisees
Application of Code of Conduct/ Standards for Practice issues	Reinforcing standards – responding to matters of concern appropriately
Accountability for overall patient management	Improved quality of staff and patient experience
Assessing and monitoring performance	Ensuring adequate orientation and training



# Responding to poor performance and the supervisee in difficulty

## Supervisor's Snapshot



### Responding to poor performance and the supervisee in difficulty

Recognising and dealing with a supervisee who is performing badly is a key skill for supervisors. Poor performance is often the result of extraneous factors, not incompetence. It is also uncomfortable, even harrowing at times, to deal with, for both supervisee and supervisor alike.

Feedback and constructive critique is an essential part of clinical supervision, especially for the struggling supervisee. In responding to poor performance from a supervisee, supervisors should be aware of organisational performance management procedures and seek support and guidance from colleagues and management where necessary.

Poor performance sometimes escalates to "supervisee in difficulty" - a supervisee who is not progressing, and may be potentially placing themselves and others at risk. The general approach to dealing with these supervisees rests on four principles: Patient safety should always be the primary consideration. Supervisees in difficulty require ongoing active supervision and support. Prevention, early recognition and early intervention are always preferred over a punitive approach in dealing with identified issues. In addition the supervisor should seek advice without delay. Having 'the crucial conversation' with the supervisee entails:

- being transparent; focussing only on observable facts and behavioural evidence
- using active listening skills and showing interest
- looking for shared and agreed solutions rather than more problems.

At all times, follow a standardised protocol.

Constructive feedback and critique is an essential part of clinical supervision, particularly for the poorly performing supervisee. Feedback and critique:

- are integral to the learning process (Busari et al., 2005)
- should be structured, clearly linked to learning requirements and adapted to professional needs
- should not be restricted to times at which they are unavoidable; the feedback process should be fluid and consistent
- can be distressing for supervisors and supervisees alike, and should be handled with tact, but not avoided (Daelmans et al., 2006)
- should offer suggestions or alternative practices rather than merely criticising

Responses to poor performance do not necessarily have to be framed in terms of right and wrong or good and bad; in many circumstances, feedback and reflection can focus on what might be more effective should the situation arise again. However, responses to poor performance should be clear and direct.

Covert or vague strategies for correcting supervisee practice or behaviour may not be received or may be misinterpreted. A lack of direct feedback risks supervisees remaining unaware of gaps in their clinical knowledge and competence (Kilminster & Jolly, 2000). In addition to unsafe practice, poorly performing supervisees may also present with other challenges such as:

- work performance
- lateness, absenteeism, ongoing errors, failure to seek advice, poor communication skills
- appropriate professional conduct and behaviour
- lack of insight into underperformance, work avoidance, bullying or demeaning others
- physical and mental health issues
- physical illness, withdrawal or self-neglect, drug or alcohol dependence, anxiety, irritability or depression
- signalling intention to resign or leave medicine (HETI, 2012)

Given that the supervisor's primary concern is the safe and quality care of the patient, it may be tempting to compensate for the supervisee's poor performance rather than remediate (Audetat et al., 2012). In the event that intervention is required, it should be linked to a clear and structured teaching strategy. Simply taking over the task or requesting that supervisees describe the procedure will rarely result in improved performance.

In responding to poor performance from a supervisee, supervisors should:

- be aware of organizational performance management procedures
- seek support and guidance from colleagues and management where necessary

## Poor performance:

- may require referral to others (e.g. line manager, employee assistance program)
- will always require documentation
- may require enactment of disciplinary procedures

Steinert (2008) has suggested there are a range of factors that contribute to poor performance and these are not necessarily in the control of the supervisee. She depicts these thus:

Knowledge	Attitudes	Skills
e.g. Gaps in knowledge of basic or clinical sciences.	e.g. Difficulties with motivation, insight, self-assessment, doctor-patient relations.	e.g. Difficulties with interpreting information, interpersonal skills, technical skills, clinical judgement, or organisation of work.
Be sure to identify both challenges and strengths.	Attitudinal problems which are usually manifested by behaviours, are often easy to identify but challenging to address.	Skill deficits often overlap with gaps in knowledge. Strengths must be identified as well.
Teacher	Learner	System
e.g. Teachers' perceptions, expectations or feelings; personal experiences or stresses; colleagues' perceptions, expectations or stresses.	e.g. Relevant life history or personal problems, including acute life stresses, learning disabilities, psychiatric illness, or substance abuse; learner expectations and assumptions; learner reactions to identified problems.	e.g. Unclear standards or responsibilities; overwhelming workload; inconsistent teaching or supervision; lack of ongoing feedback or performance appraisal.

## Managing a supervisee in difficulty

Any of the challenging situations described previously, and others, may become a “supervisee in difficulty”. Inadequate supervision has been linked with poor performance of supervisees including medical errors, sleep deprivation, stress, conflict with other medical personnel, falsifying patient records, and working while impaired (Baldwin et al., 2010).

A supervisee in difficulty may be supported by both the supervisor and operational line manager. Clear processes defining the role of each person are required in the case where the line manager is not the clinical supervisor. Where there are specific clinical practice issues, a suitably qualified senior clinician from that discipline should be involved in the process.

The saying “prevention is better than a cure” applies here. Being astute, responding to issues and having a crucial conversation early prevents a situation escalating to a major incident.

When a supervisor encounters a supervisee in difficulty, they should seek advice without delay. Experience has shown that simple interventions can be very effective if made early enough. Seek advice early from your line manager, other senior colleagues or workforce services department. Other units such as the employee assistant program and professional practice unit may also be of assistance to both supervisors and supervisees.

### Case Study



#### Having a “crucial conversation” with a supervisee

You have noticed that a supervisee is having difficulty with workload management. You know this because you have noticed that he is frequently staying back to get work done, is often working through lunch and looks exhausted and overwhelmed. You are also taking note of the issues the supervisee brings to supervision and you are finding that the supervisee is taking on too much extra work. You suspect that the supervisee is doing “above and beyond” the work that is required because he does not understand his role and is therefore anxious about performance and unsure about boundaries. You decide to address this in the next supervision session. This entails having a ‘crucial conversation’ with the supervisee.

You have the crucial conversation and, at the next session, you review the supervisee’s log. You find that the supervisee has been told by a previous supervisor “If you are really interested in being successful in this career, you need to stand out from the crowd! You need to make an impression, fit in well with the team and go the extra mile”. The supervisee has interpreted this as taking on all that he is asked to do, offering to do more than has been allocated and trying to please everyone. You have a conversation with the supervisee about the types of behaviours that are appropriate and write a daily plan with the supervisee.

## Steps in a crucial conversation

<b>Setting the scene</b>	Be transparent. Discuss and mutually agree upon what will be on the agenda for discussion.	<p>“What would you like to discuss in supervision today?”</p> <p>“Because it has been such a busy time of the year, I would also like to take some time today to discuss workload management.”</p>
<b>Discussing the evidence as a basis for your concerns</b>	Focus on observable facts and behavioural evidence. Be constructive, timely and specific	<p>“I wanted to share with you some thoughts about what I have noticed over the last few weeks.”</p>
<b>Exploring the issues</b>	Use active listening skills (empathy, questioning and open body language) and show genuine interest when trying to find out the cause of the issues.	<p>“I am really concerned that you may be overdoing it at work. I have noticed that you are staying back late on a regular basis and often not taking lunch breaks. I am wondering what sort of an impact this is having on you?”</p>
<b>Looking for solutions/ support</b>	Discuss strategies and support options to help address the issue. In this case it could be scheduling more regular supervision sessions, teaching time management skills or role playing how to say ‘no’ to requests made that are outside of role or scope of practice.	<p>“My job as your supervisor is to ensure you are supported in all areas of your work. This means looking at ways in which we can help you to manage your workload.”</p>
<b>Steps and timeline for improvement</b>	Responsibility should be shared when looking for solutions. Mutually agree on one or two steps, strategies, solutions or support options that are realistic and achievable within a timeframe. Develop goals and be directive as needed.	<p>“So, we have agreed that over the next month we will meet once per week instead of once per fortnight. Let’s make a time now for a session next week.</p> <p>For our next session, I will find some material for you to read in regard to workload management and you will keep a log of what you have been doing.”</p>

## Process for managing a supervisee in difficulty

The algorithm below outlines a useful process to facilitate managing a supervisee in difficulty.

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<b>Concern expressed about a trainee</b>	Assess the severity: <ul style="list-style-type: none"><li>• Patient safety?</li><li>• Trainee safety?</li><li>• Misconduct?</li></ul>
<b>Preliminary assessment of concern</b>	Consider potential underlying issues Consider need for further investigation
<b>Speak with the trainee</b>	Listen and assess Consider seeking advice from HR/DMS
<b>Further investigation</b>	Note findings Consider referral to expert practitioner
<b>Agree action plan and review date</b>	Seek agreement of trainee Document the action plan
<b>Implement action plan</b>	Ensure trainee is adequately supported
<b>Review</b>	Reach a conclusion: matter resolved or requires ongoing review or referral

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Source: NSW Institute of Medical Education and Training 2009, Trainee in difficulty. A handbook for Directors of Prevocational Education and Training.



# Attributes of effective clinical supervisors



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### Attributes of effective clinical supervisors

Clinical supervision requires supervisors to be clinically competent and knowledgeable because supervision is part of patient care. The clinical skills of supervisors should be up to date and evidence based. However, clinical supervisors also require certain personal attributes, supervisory skills, and clinical teaching skills.

These include, first and foremost, being available, and respectful of supervisee's needs, skilled in empathy and able to be a good role model. Assessment skills, leadership, vigilance, organisational ability, being mindful, and able to resolve conflict are also vital.

If you have missed out on developing some of these important building blocks, the Beyond Basic section below is for you. In addition, you may wish to consider accessing further training.

Clinical teaching needs time, breaking procedures into steps, sharing care and encouraging collaborative clinical management. Ask questions, sometimes even difficult ones, to discover how much supervisees know and to encourage independent thinking. Don't use questions to "prosecute" or humiliate the supervisee, or to show off your own, undoubtedly expansive, knowledge.

Giving feedback that is supportive, and informative but constructive, is an essential skill of the supervisor. There are rules for feedback that should be followed. If you don't have these in your repertoire, supervisees will not come to you with their difficulties and you won't find out what their real needs are.

# Beyond Basics:

## Attributes of effective clinical supervisors

### A matter of time

Many clinical supervisors report that they simply do not have the time to actively supervise supervisees in the way that they would like.

Time spent actively supervising supervisees is rewarded in two ways. First, active supervision improves supervisee performance, which saves time and problems with patient care. Second, supervisors who increase their involvement with supervisees 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.

Effective clinical supervisors:

- are fully trained in the area of clinical care
- understand their responsibilities for patient safety
- offer a level of supervision appropriate to the competence and experience of the individual supervisee
- acknowledge to themselves and others that clinical supervision requires time and energy and plan and organise clinical supervision as best possible
- delegate, thoughtfully and responsibly, some supervision to others in appropriate circumstances in order to develop those people's clinical supervision abilities and share the load. Consider requesting members of your team to act as buddies or mentors for supervisees

### Case Study



A consultant notices that each time she is not getting enough out of her intern. She is constantly having to speak to and spend time fixing up issues that she had anticipated the intern would manage. She finds her outpatient clinics are delayed as a consequence. She speaks to her Director of Training and rearranges her schedule so that at the start of the term she books less outpatients so she can spend time properly orienting new interns into the role. She now finds she actually spends less time with the ward overall and sees more outpatients as the intern is more productive.

#### What happened here?

The consultant identified the issues for both patient care and the intern. She sought an organisational response to make the workload more manageable. She, and others, acknowledged clinical supervision requires time, energy and organisation. You have a conversation with the supervisee about the types of behaviours that are appropriate and write a daily plan with the supervisee.

# Clinical supervision skills, personal skills and clinical teaching skills

These are essential abilities of effective clinical supervisors.

## Supervisory skills

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<b>Being available</b>	This is the big one: supervisees feel lost when they encounter a clinical situation beyond their current ability and they cannot get guidance from their supervisor.
<b>Being able to assess</b>	Assessment of performance is the process that informs supervisor's decision making regarding clinical oversight.
<b>Being in charge</b>	Supervisors should give clear and reasonable directions to supervisees. Supervisees should know what is expected of them at all times.
<b>Being vigilant</b>	Supervisors should know what is going on with patients under their care, and be ready to respond personally if necessary. Supervisors should know their supervisees, and should know what level of supervision is necessary for safe practice. Supervisors anticipate red flags and actively find the gaps in supervisee performance.
<b>Being organised</b>	Supervisors need to ensure that they and supervisees make the most of the time available.
<b>Being reflective and mindful</b>	Reflective practice promotes mindfulness. Effective supervisors are able to critically reflect on their own practice in order to identify their strengths and areas for improvement, develop self-awareness, maintain professional behaviour and engage in self-monitoring.
<b>Being able to anticipate and manage potential conflict</b>	On occasion, supervisees may disagree with the supervisor's expectations or judgement or there may be interpersonal conflict within the supervisory relationship.

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## Personal skills

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**Empathy** A good supervisor uses insight and understanding to support the supervisee and recalls what it was like to be a supervisee in the clinical environment.

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**Respect** Showing respect for supervisees and others engenders respect.

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**Role model** Effective role modelling requires that the supervisor has a comprehensive knowledge of what it is that they are modelling, and what it is that they require the supervisee to understand about the task (Cote & Leclere, 2000).

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**A direct manner and honesty in communications** A common problem for supervisees is uncertainty about what their supervisor thinks or wants. Honest feedback from supervisors is highly valued. A positive approach to feedback also reduces the likelihood that supervisees will hide mistakes and gaps in their competence.

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

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

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**Willingness** To allow the supervisee to grow, be independent and make some mistakes.

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# Clinical teaching skills

Providing hands-on care for patients in the presence of supervisees and discussing what is being done is a core aspect of clinical teaching. Clinical teaching:

- links theory and practice: that is, not only demonstrating skills but explaining the logic and the evidence behind the practice
- provides opportunities to practice skills.

## Effective clinical teachers:

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**Demonstrate their passion** For practice and clinical teaching and are effective role models (Paice et al. 2002).

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**Make time and space available for the supervisee to be hands-on** Breaking procedures into steps, providing direction, sharing care and encouraging collaborative problem solving.

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**Use the Socratic method** Asking questions to discover the state of the supervisee'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 supervisees engaged, "on their toes", listening and thinking. One proviso: don't use questions to "prosecute" or humiliate the supervisee, or to show off your own expansive knowledge.

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

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**Give feedback** That is timely, specific, constructive and given in an appropriate environment. Supervisors who give feedback should also invite feedback from the supervisee, with a view to improving their teaching technique.

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**Provide appropriate learning experiences and resources** Know what is available to help trainees and selecting material pitched at the appropriate level. Apply the FAIR principles: provide feedback to the student, engage the student in active learning, individualise the learning to the personal needs of the student and make the learning relevant (Harden & Laidlaw, 2013).

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## Tips for being an effective supervisor

- Just listen in the first instance
- Create a safe and supportive environment free from physical, verbal or psychological control
- Establish and develop a professional relationship built on mutual respect and trust
- Build rapport and actively listen. Aim to listen more than you talk.
- Establish the focus of your supervisory relationship, including an agreement for working together
- Work together to identify, agree upon and realise the supervisee's goals
- Empathise. Allow the supervisee to express feelings. Remain sensitive and patient. Recall your own experiences of clinical supervision.
- Clarify how the supervisee would like feedback conveyed
- Provide honest and constructive feedback
- Ask appropriate and relevant questions that facilitate communication and clarification
- Identify and encourage strengths in the supervisee
- Encourage the supervisee to think reflectively and critically explore options together
- Maintain confidentiality
- Manage any personal frustrations or irritations you may experience without displacing these to the supervisee
- Ensure your supervision time is free from distractions or non-essential interruptions

(Adapted from Cohen 2005, Rose 1999)



A medical student is on a 4 week placement in a rural general practice. You are his supervisor. It is the end of the first week of the placement. The student has been well received in the practice by the patients and the staff. Other staff have commented on how personable he is and how he seems to fit in well and enjoy talking with people. You meet with the student on Friday and provide this positive feedback and say you would like the student to be more active in patient consultation now that he has had some time observing the practice. You suggest that during the next week, the student conduct some initial medical history taking in a spare room in the practice with patients who agree to this. That afternoon, you take the student with you to the Multi Purpose Service to do rounds of inpatients.

The next week, the student is absent from the practice on Monday. On Tuesday, he arrives and meets with a patient as suggested. You join the patient and the student and ask for a report on the patient's history. The student tells you that he and the patient have had a great time having a general chat and shared a few jokes. The patient tells you the student is wonderful and so full of life.

You complete the consultation with the patient and ask the student to join you in the next consultation and make a time to discuss things at lunch when the practice is quieter. At lunch, you meet with the student privately and ask him how he thinks he went in the morning. The student says "Not really well. I just can't focus on things that are important for the history." You ask him about his understanding of the aspects of taking a history and find he can describe all the elements. You decide to ask the student how he has been feeling in the practice. The student tells you:

"Everyone is really great. I just feel so overwhelmed by it all. Things are going really fast, I have seen lots of things but it has been really full on. I am concerned I am not up to this... What if I say or do something wrong?"

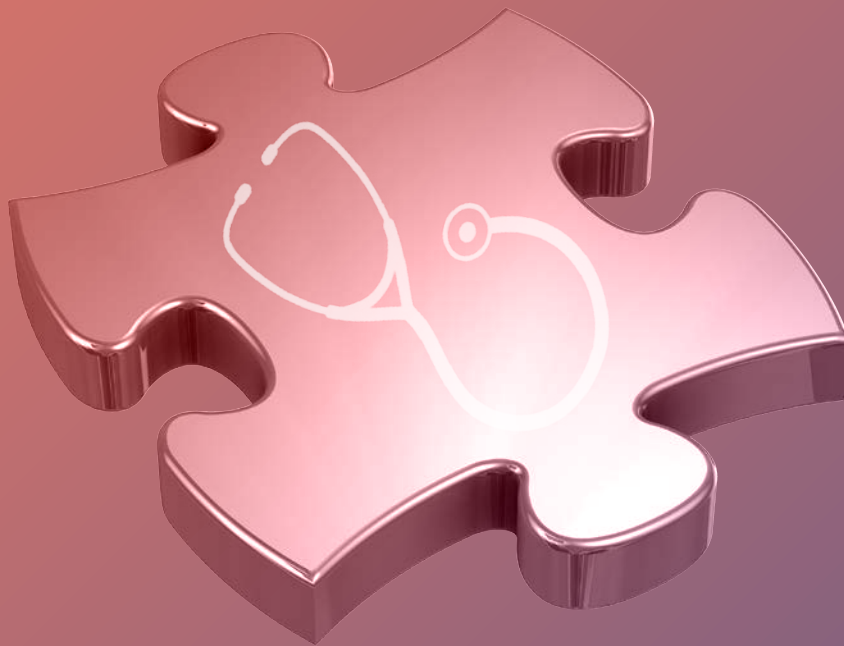
You empathise with the student and share with the student your own experiences of being a medical student. You and the student discuss that the student has done well in being able to identify what his concerns are and you are not expecting him to perform at the level of a registrar. Rather, you are providing experience to guide his work towards acquiring additional knowledge and skills. You and the student decide that rather than attending every consultation possible, over the next two days you will give the student opportunity to practice with you having conversations with patients and you identify a few key questions for him to ask in the next three consults.

### What happened here?

Although things seemed to be going well for the student, the supervisor provided an experience that identified aspects in which the student needed development and support. The supervisor was able to discriminate between his expectations of a student and a more experienced supervisee. Although this was initially distressing for the student, the supervisor listened and did not dismiss the student's concerns; identified the issue was not due to a lack of knowledge; provided support and guidance and structured the student learning by taking charge and setting manageable goals.



# Clinical oversight: the conerstone of clinical supervision



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### Clinical oversight

Recently the concept of oversight (Kennedy et al., 2007), along with that of entrustable professional activities (Ten Cate, 2005) have been developed quite extensively. The term "clinical oversight" was initially advanced to describe patient care activities performed by supervisors to ensure quality of care. The term 'entrustable professional activities' describes clinical activities that might embrace a number of competencies, but are required activities in the clinical setting, for example, 'Giving morning report after night call'. The supervisor's job is to identify which of these activities is entrustable to the supervisee, and not focus on testing underlying competencies.

The responsibility for clinical oversight and supervision is the same whether in the general practice, at the patient's bedside, on a ward round, or on the telephone to the junior clinician. There are specific ways to use these concepts. Oversight, for example has a number of levels. Deciding on which type of oversight a supervisee needs means that one general level is applied until the supervisee shows they are capable to move to a more remote level of supervision.

By contrast, using 'entrustable activities' means looking more closely at supervisees' activity and making a decision activity by activity. Ten Cate (2006) sums it up as:

*If clinical supervisors think of their trainees, they would be able to identify those whom they would entrust with a complex medical task because they will either perform well and seek help if necessary or not accept the task if they don't feel confident. Supervisors often know who to pick, even if they can't tell exactly why.*

*This gut feeling does not always match with formally assessed knowledge or skill, but it may be more valid for its purpose. No external body or procedure can replace this type of expert judgment. One reason is that trust in the judgment of a supervisor implies a personal involvement in the outcome of the activity of the trainee. If this is your trainee, his or her accomplishments are part of your accomplishments. If it's not done well, you will have a problem.*

In reality, supervisors often use a combination of oversight and decision making about entrustability, as clinical oversight is a process that determines when a supervisee can be entrusted with an activity and thus require backstage oversight. As supervisees develop, they then become entrusted to supervisors others (Ten Cate et al., 2010).

# Beyond Basics:

## Clinical oversight

### Supervision as active and supportive oversight

Supervision is passive when the supervisor's role in patient care relies on routine activity such as ward rounds or independent consultations, and the supervisee, working mostly without direct supervision, is expected to identify any need for additional advice or assistance. In these cases, the supervisor is often involved only in exceptional circumstances where the patients complain or experience adverse events.

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support supervisees when they need help, whether or not a request for help is made. Active supervision acknowledges that some supervisees, or all supervisees in some situations, are "unconsciously incompetent" (Race, 2001). 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 and/or their own or others' welfare may be at risk.

Active supervision requires the supervisor continually to seek cues or evidence that more direct oversight is needed or that direct patient care by the supervisor is required. A benchmark study in the United States found that when clinical supervisors saw the patient themselves rather than relying on supervisee reports, they judged the patient to be more seriously ill (Gennis & Gennis, 1993). Studies since that time have affirmed this. This finding will resonate with the experience of many supervisors.

The elements of active supervision have been described as:

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<b>Routine oversight</b>	Clinical oversight activities that are planned in advance and must be sufficiently vigilant to pick up clues that the supervisor's direct intervention in patient care is needed.
<b>Responsive oversight</b>	Clinical oversight activities that occur in response to supervisee or patient specific issues and is when the supervisor actively seeks evidence of supervisee performance and responds with more a "hands-on" or "hands-off" approach to supervision.
<b>Direct oversight</b>	Refers to instances in which a supervisor moves beyond oversight to actively provide care for a supervisee's patient.
<b>Backstage oversight</b>	Clinical oversight activities of which the supervisee is not directly aware. In backstage oversight, the supervisor ensures that care is progressing by appropriately monitoring the supervisee's performance e.g. by 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 (Kennedy et al, 2007).

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## A key concept: "Hands-on, Hands-off"

An effective supervisor knows when to give supervisees direction, and when to give them freedom of action. To move the supervisee from consciously incompetent to consciously competent, the supervisor must actively calibrate the level of support provided and move between empowering and facilitative behaviours. Ledema et al. (2008) have characterised this as knowing when to use "Hands on/Hands Off" supervision.

"Hands-on"/facilitative supervision	"Hands-off"/empowering supervision
<p><b>Positive examples</b></p> <ul style="list-style-type: none"><li>• Guidance on procedures, skills training sessions</li><li>• Seeing patients with consultant</li><li>• Discussing mistakes</li><li>• Opportunities to discuss patient management</li></ul>	<p><b>Positive examples</b></p> <ul style="list-style-type: none"><li>• Identifying crucial supervision moments</li><li>• Having enough room for developing independence</li><li>• Feeling trusted</li><li>• Opportunities for de-briefing</li></ul>
<p><b>Potential negative outcomes</b></p> <ul style="list-style-type: none"><li>• Supervisee feeling intimidated, humiliated, watched</li><li>• Supervisee feeling disempowered</li></ul>	<p><b>Potential negative outcomes</b></p> <ul style="list-style-type: none"><li>• Supervisees being left alone to deal with challenging situations</li><li>• Supervisees feeling abandoned and unable to contact senior staff</li><li>• Needs for de-briefing not met</li></ul>

## Hands-off supervision is not an absence of supervision

Research suggests that when clinical supervisors decide to provide hands off supervision, they use their tacit professional knowledge and base their judgements on the Dimensions of Trustworthiness demonstrated by a supervisee, categorised by Kennedy et al., (2008) as:

- **Knowledge and skill**
- **Discernment:** Supervisee's awareness of the limits of his or her clinical knowledge and skill
- **Conscientiousness:** thoroughness in data gathering and dependability in following through with assigned tasks
- **Truthfulness:** absence of deception in interactions with supervisor

As the supervisor gains trust in the supervisee and clinical supervision continues, the supervisee usually develops to the point where they demonstrate sufficient competence to undertake what Ten Cate (2005) has described as Entrustable Professional Activities (EPAs). Writing about the supervision of trainees, Ten Cate (2013) observes:

*Trust is a central concept for safe and effective health care.*

*Patients must trust their physicians, and health care providers must trust each other in a highly interdependent health care system. In teaching settings, supervisors decide when and for what tasks they entrust trainees to assume clinical responsibilities. Building on this concept, EPAs are units of professional practice, defined as tasks or responsibilities to be entrusted to the unsupervised execution by a trainee once he or she has attained sufficient specific competence.*

In general, trainees need significant hands-on supervision at the beginning of training and increasing amounts of hands-off supervision as they progress. Determinants of when supervisees are entrusted with activities are supervisee, supervisor and context dependent. Sterkenburg et al., (2010) have commented:

*When supervisors entrust learners, including medical trainees, with only routine activities, learning is likely to be too slow or absent. Conversely, too much responsibility required at too early a stage may result in adverse effects for – in the case of medicine – both the patient and the trainee.*

The frequency of contact and the strength of the relationship between the supervisor and supervisee, the sooner the supervisor entrusts the supervisee with professional activity. The ability to holistically assess a supervisee's performance is a key component in determining when to entrust the supervisee with activity.



### Assessment and feedback

Assessment is a critical process in undergraduate programs and much effort is put into making it as reliable and as valid as possible. In the workplace, however, most supervisors will routinely, and perhaps unconsciously, be assessing and monitoring the clinical performance of the supervisees, particularly when providing clinical oversight. However, a more formal assessment process can be useful at times, and this requires explicit adherence to principles of assessment.

Taking someone aside and assessing them implies, if only for good manners, that some feedback will be given. Research suggests that feedback is not straightforward, especially in the health professions. There are various models available, depending on the context, but all share common fundamental principles. Feedback needs to:

- acknowledge the supervisee's distress if they make a mistake
- be given supportively, identifying and praising activities done well
- be given constructively, identifying areas for improvement
- be used during 'hands on' supervision to guide supervisee's practice
- follow a protocol so that all these elements are present

# Beyond Basics:

## Assessing performance and giving feedback

Assessment should be:

- fair (equitable)
- valid (assesses against specific criteria)
- reliable (achieve the same result under similar circumstances with a range of assessors)

Distinction should be made between formative and summative assessment. Formative or developmental assessment is closely linked to teaching and learning while the outcomes of summative or end point assessment may impact progression and certification of supervisees. In order to conduct meaningful assessment, supervisors should have a sound appreciation of the expected level of performance, the criteria against which performance is appraised and the standard of performance expected.

### Giving feedback

According to the Junior Medical Officers' Forum (HETI's representative body of prevocational trainees) and other sources, supervisees highly value verbal feedback on progress and skill development. The provision of timely, appropriate and ongoing feedback is integral in the process of active supervision. Feedback should not be entirely reactive, and should be delivered in a structured and proactive manner rather than being restricted to moments where it is unavoidable (Daelmans et al., 2005).

### **Consequences of a lack of clear feedback to a supervisee who is not performing adequately:**

- Clinical care is not as good as it could be
- Anxieties and inadequacies are not addressed. The supervisee carries these on to the next experience
- When weaknesses are exposed later, the supervisee has difficulty accepting criticism because of previous "good reports"
- Others are blamed when the supervisee is unsuccessful
- Learning is inhibited, career progression is delayed
- Other, more frank, supervisors may be devalued and disregarded later. (Cohen, 2005)

<b>Be timely</b>	Give feedback on an event as soon as possible. Don't wait until the end of term. However, pick a good moment for feedback (not the supervisor or supervisee is exhausted, distracted or upset).
<b>Be consistent</b>	Feedback on performance should be a frequent feature of your relationship with those you supervise.
<b>Be specific</b>	Vague or generalised praise or criticism is difficult to act upon. Adopt a straightforward manner and be clear.
<b>Be constructive</b>	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 supervisee makes an error, feedback needs to be unambiguous ("You didn't use the correct technique for tying that knot. Next time ...").
<b>Choose an appropriate setting</b>	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.
<b>Use attentive listening</b>	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.

### Key points for supervisors providing feedback

- Address issues or concerns early
- Have a plan and establish a relationship
- Know the boundaries and scope of your role and refer as necessary
- Seek advice
- Do formal reporting/documenting of matters of concern
- Follow organisational processes and use other resources/processes



## Frameworks for giving feedback

In addition to the well known 'feedback sandwich' where negative feedback is given between positive feedback (i.e positive- improve-positive), three major models for giving feedback used in medical education are:

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### Agenda-led/ Outcomes Based

- Start with learner's agenda
- Focus on required outcome
- Encourage self-assessment and problem solving
- In groups, involve all members
- Provide balanced feedback
- Make and rehearse suggestions
- Be respectful
- Structure and summarise (London Deanery, 2012)

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### SET-GO

- **S** – what I saw
- **E** – what else did you see?
- **T** – what did you think?
- **G** – clarify a goal
- **O** – offer solutions/strategies (Silverman et al., 1997)

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### Pendleton

- Ask the learner how they felt
  - Ask the learner what went well and why
  - Ask group/tutor what went well and why
  - Ask learner what could be done better and how
  - Ask group/tutor what could be done better and how
  - Summarise strengths and up to 3 things to concentrate on ( Pendleton, et al., 1984)
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# Clinical teaching



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### Clinical teaching

There are some essential features that will make your choice of content simpler and more effective.

**Clinical teaching is not a substitute for debriefing after emergencies, critical or distressing situations.**

First, make sure you know what the supervisees need, rather than what you, or they, think they want. Teach at the right level for the 'student'. Set goals for them and once they think these have been achieved, provide feedback.

Involve patients in teaching, both through informed consent, and as teachers about their own condition.

Use the principles of learning, recognising that more learning takes place with motivated learners and large quantities of feedback. Get learners to reflect on their learning, or difficulties with it. In addition, reflect on your teaching and supervision: what when well, what could have been done better?

#### **"Carpe Diem!"**

Patients are sick and in hospital for very short periods, don't lose an opportunity to teach on a patient who might be a good example of a core clinical principle. Rare patients are exciting, but patients who illustrate the potential for avoiding errors in diagnosis, or controlling fluid balance, or post operative management, will be more beneficial to the beginning supervisee.

#### **Don't try to teach everything.**

Actively engage the supervisees; be creative.

For example, give enough information to set learners on track, and then ask them to complete the picture themselves. Set tasks that require learners to act on the information you have provided.

**Remember, the three most important words in teaching and learning are "I don't know".**

Occasionally get a colleague to watch you teach or supervise; ask them to make suggestions for improvement.

In addition to being an important skill to acquire, handover can be a stimulus and focus for other learning activities. For example, supervisors should 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. Supervisors can select particular patients at handover as the focus of clinical teaching.

Handover is an excellent opportunity for junior medical staff to identify a patient case suitable for the junior staff to lead a teaching session about. Ask supervisees to select a case to present in more detail.

In the section that follows we have tried to provide a strategy for almost every teaching situation you might find yourself in.

It is important to distinguish between the clinical response you require the supervisee to provide and the learning process. There have been examples where supervisors felt that they gave clear instructions about patient care they expected the supervisee to provide; however, supervisees assumed it was just a discussion of the patient situation and that other personnel were taking action.



# Beyond Basics:

## What makes clinical teaching effective and how can I do it better?

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**Collaboration and active involvement**

Teach the individual: if appropriate, ascertain what the supervisee is interested in and then direct your teaching to this motivation. If there is particular knowledge or skills that must be acquired, provide the rationale for this. If the supervisee remains disinterested in what is being taught, consider whether this is a signal that the supervisee may be in difficulty.

**Adults like to have input into their learning**

**Relevance to the clinical duties currently required of the supervisee, or to their future career plans**

Be clear about the purpose and outcomes of the clinical teaching. Align it to frameworks such as the Australian Curriculum For Junior Doctors & Post Graduate College curricula, undergraduate curricula and work requirements as necessary. Be clear what teaching is intended to be applied in the present and what is teaching for future application in order to ensure the supervisee does not work outside his/her scope of practice.

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**Setting clear learning goals with the supervisees**

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

**Expectations are clear**

**Specific; Measurable; Attainable; Relevant and Timely**

Document SMART learning goals

**Giving feedback so that supervisees know how they are going**

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

Adult learning is a collaborative process.

**Seeking feedback so that you know how effective teaching has been**

As lifelong learners, supervisors can modify their teaching if necessary. You may find it useful to attend staff development opportunities such as Teaching on the Run.

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**Appropriateness to the level of the supervisee**

A failure of some teaching is that time is spent teaching supervisees things they already know. Conversely, others can be taught things that are beyond their present level and be overwhelmed or confused about what is expected of them.

**Teaching by guided questioning. Asking and encouraging thinking**

The advantage of guided questioning is that it reveals what supervisees do know and invites them to extend their knowledge. But don't turn questioning into a grilling. Make sure supervisees are provided with time to think about their responses and if they require more time to process what is being taught, offer to continue the discussion later once they have had a chance to reflect.

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Clinical teaching is a vital part of active supervision. It enables development of knowledge, skills and professional identity (Scheffer et al., 2010). Along with the ability to assess and give feedback, clinical teaching requires an appreciation of the implications of teaching in the presence of patients, and an ability to apply the principles of adult learning, reflective practice and time management.

### Teaching in the presence of patients

Teaching in the presence of patients is at the heart of effective clinical training and supervision; it is the place where theoretical knowledge is applied in the real world, with actual patients. Teaching during rounds or consultations is enjoyed by most patients and considered by supervisees to be the most effective way to integrate knowledge and skills to perform in the clinical context.

Teaching in the presence of patients can involve learning about diagnostics, communication and thinking skills and procedural knowledge and clinical skills.

Some important principles apply to teaching in the presence of patients. The patient's safety, comfort, privacy and confidentiality are paramount and should be monitored at all times.

- If possible, provide advance notice to the patient
- Obtain the patient's consent wherever possible, prior to the teaching session
- Reassure the patient that his/her safety is the priority for you and the learner
- Thank the patient and invite them to ask any questions they may have
- Ascertain the learner's knowledge base prior to engaging with the patient - don't ask questions the learner might give incorrect answers to in front of the patient
- Ensure all relevant introductions are made
- Explain all procedures and discussions to the patient as teaching occurs
- Invite the patient's feedback
- Provide constructive feedback to the learner away from the patient
- Allocate sufficient time for the learning experience
- If the learner appears to be struggling or is off track, make a smooth transition to take over the clinical interaction

## Principles of adult learning

- Adult learners need to be respected, valued and acknowledged for their past experience and have an opportunity to apply this experience to their current learning
- Adults learn best in environments that reduce possible threats to self-concept and self-esteem and provide support for change and development
- Adult learners are highly motivated to learn in areas relevant to their current needs, often generated by real life tasks and problems
- Adult learners need feedback to develop
- Adult learners have a tendency towards self directed learning and learn best when they can set their own pace
- Adults learn more effectively through experiential techniques (e.g., discussion and problem solving) (Bennett et al., 2012; Brookfield, 1998; Brundage & MacKeracher, 1980)

This means that, as supervisors, doctors create environments which enable supervisees to identify their current knowledge and skills, to offer learning opportunities, provide constructive feedback and engage in dialogue and reflection on practice.



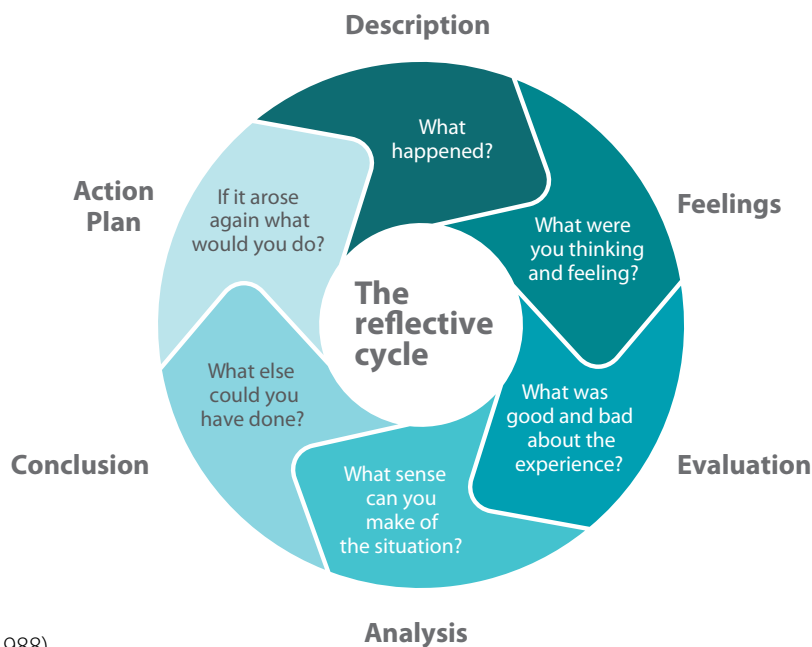


# Reflective practice

One of the most important skills health professionals can develop is the ability to critically reflect on their own practice. This includes identifying their strengths and weaknesses, determining actions required to improve their skills and developing clinical reasoning skills to ensure the delivery of safe patient care.

Reflective practice is an effective process to develop self-awareness and facilitate changes in professional behaviour. It is used in all forms of clinical supervision. Reflection can occur before, during or after an event (Sandars 2009). When reflection occurs in supervision, it can be in relation to reflecting on day-to-day clinical practice, triggered by a challenging clinical encounter or in anticipation of having to manage a complex situation. It is imperative that reflective practice is conducted in a supportive environment to allow individuals to freely share information that promotes learning. There are many models of reflective practice that can be used in supervision. One such model is Gibbs' (1988) model of reflection.

## Model of reflective practice



Gibbs (1988)

## Teaching techniques to encourage reflective practice include:

**During structured professional clinical supervision sessions,** the supervisee provides the supervisor with an overview of an issue or incident and the supervisor uses questioning to encourage reflection on its meaning and their learning.

**During clinical teaching,** the learner is asked to think about what they did well, what they could improve and how they would do things next time.

**During a regular review and goal setting session,** the supervisee is asked to sum up their week and identify their goals for the following week.

**Reflective journal/record keeping,** is a self-directed activity which can be used in any approach to clinical supervision, where the supervisee is guided by a template of key questions to record their experiences, work through the issues and reflect on their learning. They can then use this as a tool for discussion with their supervisor or to keep as a record of continuing professional development.



## Top Tips for clinical teaching

<b>Seize the teaching moment</b>	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 learner'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 learner understanding of what occurred and give quick feedback.
<b>Develop teaching "pearls"</b>	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.
<b>Focus the learner</b>	Start any teaching by setting up the importance of the lesson. Teaching is more effective if it is tailored to the learner's interests, ambitions and current level of knowledge and ability. Answer the question: Why should learners pay attention to what you are about to teach?
<b>Focus the lesson</b>	Don't try to teach too much at once. Try not to repeat what the learner already knows. Clinical situations are complex, but limit the lesson to the key aspects that are at the leading edge of the learner's knowledge. Procedures can be broken down into steps, not all of which have to be covered in one lesson.
<b>Demand independent learning</b>	Don't try to teach everything — give enough information to set learners on track, then ask them to complete the picture themselves. Set tasks that require learners to act on the information you have provided. Keep learning open-ended.
<b>Use the Socratic method</b>	Ask questions to discover the learner's knowledge and to encourage independent thinking and problem-solving. Questions keep learners engaged, "on their toes", thinking and listening. One proviso: don't use questions to "prosecute" or humiliate the learner, or to show off your own expansive knowledge.
<b>Invite learners to set the agenda</b>	It is a basic principle of adult learning that the learner should be involved in decisions about the direction and content of learning. Your ultimate objective as a supervisor is to foster the learner's ability for self-directed, lifelong learning.
<b>Make learning an active process</b>	Active participation is integral in the development of both skills based expertise and a professional identity.
<b>Encourage questions</b>	Learner questions should always be treated with respect. You may be surprised that they did not already know something, 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".
<b>Teach evidence-based medicine</b>	Build a lifelong learning attitude in your learners and model this yourself. 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.
<b>Evaluate your own practice as a teacher</b>	How well did your learners 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 learner outcomes. Seek feedback from your learners. Compare notes with your peers. Access professional development opportunities as necessary to develop your teaching skills.

## Developing clinical teaching skills

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 two to three 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

Visit the HETI website for information about Teaching On The Run workshops and contacts in New South Wales.

Teaching On The Run: teaching tips for clinicians is an excellent pocket book full of distilled practical advice from the workshops. It can be purchased online from the eMJA Shop.

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





## Top Tips for time management during clinical teaching

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<b>Budget your time</b>	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: <ul style="list-style-type: none"><li>• Student: a clinical sign to elicit.</li><li>• Prevocational trainee: a prescribing question that explores knowledge of physiology and pharmacology, or a test to be interpreted.</li><li>• Registrar: questions about the evidence base behind a treatment decision.</li></ul>
<b>Use one-minute teaching moments</b>	Develop mini-tutorials on key topics that break complex issues into simpler teachable parcels.
<b>Recycle</b>	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.
<b>Delegate and double the learning</b>	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.
<b>Share</b>	Use staff meetings to share ideas for mini-tutorials and teaching points, and create a bank of prepared teaching for all supervisors to use.

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## Top Tips for teaching during rounds

- 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

## McLeod's guidelines for effective ward rounds

<b>Planning</b>	Brief trainees on the purpose of rounds and seek information about trainee expectations and abilities.
<b>Timing</b>	Select patients for discussion.
<b>Preparation</b>	Do background reading for selected cases.
<b>Patients</b>	Effective 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.
<b>Location</b>	Bedside for the experience of an actual patient, (or with a patient in a general practice setting or another community setting).
<b>Format</b>	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).
<b>Emphasis</b>	Problem-solving rather than fact-accumulating.
<b>Trainee participation</b>	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.
<b>Assessment and feedback</b>	Is for everybody on the team. Questions should be encouraged.

(McLeod 1986)

# One-minute teacher approach

Use the one-minute clinical teacher approach proposed by Neher et al., (1992).

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**Step 1:**  
**Getting a commitment** The teacher encourages learners to articulate their opinions on the differential diagnosis and management rather than giving their own conclusions and plans. The teacher must create a safe learning environment so that learners feel safe enough to risk a commitment - even if it is wrong.

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**Step 2:**  
**Probing for supporting evidence** The teacher should encourage learners to 'think out loud' and give their rationale for the commitment they have just made to diagnosis, treatment, or other aspects of the patient's problem. Teachers should either validate learners' commitments or reject them gently if flawed.

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**Step 3:**  
**Teaching general rules** Teachers can guide learners to understand how the learning from one patient can be applied to other situations. The learner is primed for new information they can apply to a given patient as well as future patients. If the learner has performed well and the teacher has nothing to add, this microskill can be skipped.

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**Step 4:**  
**Reinforcing what was done well** It is appropriate to use this microskill every time the trainee has handled a patient care situation well. Effective reinforcement should be specific and behaviour based and not vague. Positive feedback also builds the trainee's self-esteem.

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**Step 5:**  
**Correcting mistakes** Negative or constructive feedback is often avoided by clinical teachers, but this is vital to ensure good patient care. Encouraging self-assessment is a good way to have the learners realise their mistakes themselves and if they have identified their errors, they can be given positive feedback on their self-reflective capabilities. If the teacher has to point out mistakes, this must be specific, timely and based entirely behaviour based. (Ramani & Leinster, 2008).

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An approach to clinical teaching of registrars in general practice has been documented by Ingham (2012). This process, with the acronym WW-DOC, may be applicable to other consultation settings as it is claimed that “Distinctive features of this model include the supervisor being introduced as providing a ‘second opinion’, the registrar retaining control of the consultation and the use of ‘thinking aloud’ as a teaching strategy” (Ingham 2012)

W	Who is present – introductions
W	Why has the supervisor been called in? Except where there are other reasons, such as handover of care, the registrar will explain this to the patient as a ‘second opinion’ rather than as ‘needing help from my boss’
–	A pause for questions – time for the supervisor to ask for more information from patient or registrar as needed
D	Discuss the case using ‘thinking aloud’ rather than the supervisor questioning the registrar. ‘Thinking aloud’ is used to share and explore clinical reasoning. For example: ‘the absence of tachycardia makes me think pulmonary embolus is unlikely’ or ‘this doesn’t appear to fit any pattern, so I wonder if ‘wait and see’ might be the best approach’ or ‘I was thinking of a trial of an inhaled steroid, what do you think of that approach in this situation?’
O	Opportunities for learning – identify issues for later consideration (or there is a standing agreement that all interrupted consultations will be discussed later)
C	Conclusion – the registrar summarises the outcome of the discussions and the supervisor leaves the room for the registrar to conclude the consultation





### 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.

Following further treatment of the patient, the supervisor asked the intern if he had learnt anything from the event.

#### What happened here:

- The supervisor was present with the intern
- The supervisor invited the intern to identify what was known about the patient
- The supervisor worked with the intern to explore alternative diagnoses and extended the intern's thinking
- The intern was able to recognise salient aspects of the patient's condition with guidance from the supervisor
- The supervisor monitored the intern in further activity





### CASE 2

A supervisor who is a respiratory physician and an RMO are at the bedside of a 45-year-old woman admitted with breathlessness. The supervisor has previously asked the patient if he is comfortable with him teaching her case, and the patient agreed to this.

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 teaching interaction should be 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.

Once away from the patient, the supervisor asks the RMO to think about how his jocular response about his not needing to know about abnormalities in the respiratory system may have been received by the patient who he had to provide care for currently, and reminded the RMO that while aspirations were important, quality experiences for current patients should be met.

#### What happened here:

- The supervisor provided direct feedback to the RMO about performance expectations in a way that was patient and RMO focussed
- The supervisor corrected feedback and correction of technical errors
- The supervisor began a learning experience aligned to the RMOs area of interest and then moved to a more broad focus

## Teaching procedural skills

The Australian Curriculum Framework for Junior Doctors (Confederation of Postgraduate Medical Education Councils 2012) includes an extensive list of skills and procedures that prevocational trainees need to acquire for the safe treatment of patients.

Skills training can begin with virtual experience: texts, videos, online tutorials, simulations, but many skills need to be completed in the workplace with actual 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 (1998) and adopted in Teaching on the Run, is:

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**Step 1: Demonstration**    Trainer demonstrates at normal speed, without commentary.

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**Step 2: Deconstruction**    Trainer demonstrates while describing steps.

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**Step 3: Comprehension**    Trainer demonstrates while learner describes steps.

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**Step 4: Performance**    Trainee demonstrates and describes steps.

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## Top Tips for skills teaching

- Call for focus: set the scene and motivate the supervisee (importance to supervisee, to patient, to system)
- Don't forget fundamentals: hygiene and aseptic technique; patient communication and consent
- Demonstration: Make sure the supervisee 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 supervisee already knows. Review unknown steps in more detail
- Demonstration by the teacher can be combined with performance by the supervisee
- Repetition is the key to skills training, with the focus of the lesson moving forward each time
- A simple scale for assessing supervisee 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	Supervisee unable to proceed without step-by-step instruction

In addition to teaching procedural skills, there will usually also be opportunity for learning and supervision around other skills sets, including:

- identifying, collecting and combining information
- problem solving and decision making
- handling treatment of disease
- practical skills and illustration of technical equipment
- communicating with patients and other health professionals
- handling organisations demands



An intern and a 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. The registrar observed the intern for a short while and affirmed that the intern was effective in use of the system.

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

### What happened here:

There was:

- an appropriate response to maintain patient safety
- an opportunity for teaching the procedural skill of apply bag valve mask was identified
- a teaching procedure embedded in clinical practice
- a registrar who monitored the outcome of the teaching and gave positive feedback

## Handover and clinical teaching

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 (NSW Department of Health, 2010b). Junior doctors need to be encouraged to value handover and to see it as an essential and integral part of their daily work.

All NSW Health staff should be familiar with the ISBAR framework for communications at handover.

<b>I</b>	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)”
<b>S</b>	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>B</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)
<b>A</b>	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 ...”
<b>R</b>	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 ...”

Handover of patients and the transfer of their care is an entrustable professional activity to be developed as:

*The handover requires the application and integration of clinical and communication skills, and an understanding of the systems of care, which must come together in one, time-limited and highly constrained activity (Ten Cate & Young, 2012).*

To support learning, the role of the supervisor is to model handover skills, observe and provide feedback to the supervisee. In ensuring clinical safety, the role of the supervisor is to observe the supervisee providing handover and apply clinical oversight as necessary.

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

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 (NSW Department of Health, 2010). 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.



## Other opportunities for clinical teaching

### After emergency or critical incidents

When there are emergencies or critical incidents it is important to review the event afterwards and ensure the supervisee has adequate support and debriefing as part of clinical supervision. It may also be opportune to use analysis of the situation as a clinical teaching opportunity. A few pertinent questions to reveal the supervisee's understanding of the key issues may be all that is required to stimulate learning.

### Follow up on after-hours episodes

Most of the week occurs "after hours". Much of the supervisee'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 supervision is provided.

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

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

### Involve in consultation

Advice from consultants and registrars from other specialist teams is often required for patient care. When a supervisor consults another team, the supervisee should be included if possible because good communication skills are best acquired through role modelling. Delegating a consultation to a supervisee without hands-on supervision is only appropriate in considered circumstances, but can be a key learning opportunity, as the supervisee must distil the history, examination and progress, as well as frame the clinical question to be answered. Supervisees often report being asked to arrange consultations without understanding why. Supervisors need to check that the supervisee 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.

## Other opportunities for clinical teaching (continued)

### Develop telephone communication abilities

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 supervisee during clinical encounters. Because the supervisor cannot see or touch the patient, there is an increased focus on the supervisee's communication skills. Fear of difficult conversations with consultants and registrars can discourage junior doctors from making a phone call at the time it is most need. Supervisors need to support the supervisee's use of the phone and develop their skills in presenting appropriate information in all contexts. Particularly in non-urgent situations, the supervisor can work with the trainee to clarify the supervisee's phone communication technique:

- Practise the ISBAR communication framework
- Provide feedback to the supervisee on the supervisee'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 supervisee to do the same



# References and Resources



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## Resources

Resources, plus updates to this handbook, are available online: [www.heti.nsw.gov.au](http://www.heti.nsw.gov.au)

- Prevocational trainee action plan template.
- The Doctor's Compass
- The Doctor's GPS: A career guide for JMOs 2012
- The DPET Guide
- The JMO Managers Guide
- Trainee in Difficulty: a management guide







# The Superguide

A handbook for supervising doctors

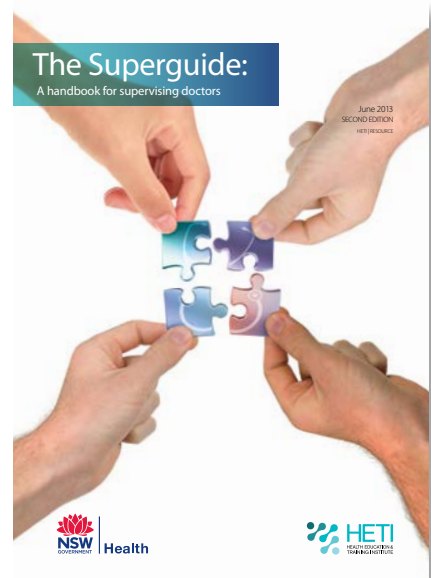
HETI has produced this book in response to the identified need for improved clinical supervision at the point of care. This book is focused on practical advice to improve the effectiveness and educational value of clinical supervision.

We hope this handbook will be useful to medical staff who supervise junior medical officers and trainees as well as enhance clinical supervision of undergraduate students and peers in a range of settings, including general practice.

The book provides information about:

- Supervising doctors in ways that contribute to the safety and better medical care of patients, including the need to respond to poor performance
- Effective methods of contributing to the education, welfare and professional development of doctors
- Assessing supervisees

Many clinicians who provide clinical supervision also engage in teaching in classrooms and simulated learning environments.



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