Building Capacity for Clinical Supervision of Non-fellowed Doctors

2023

1. Clinical supervision in medical practice

1.1 Clinical supervision is an intrinsic part of medical practice and training, and supervising trainees and those adjusting to the Australian system is a core component of our health sector. Effective supervision helps to develop medical professionalism and contributes to improved patient safety, better health outcomes, improved performance, and faster acquisition of skills by trainees.

1.2 As increased numbers of medical graduates progress through prevocational and vocational training, and pressures on health system funding and service delivery continue, it is imperative that high quality of supervision is maintained and that clinical supervisors are supported and properly remunerated to train a fit for purpose medical workforce.

1.3 Clinical supervision includes the provision of guidance and feedback on matters of professional and educational development in the context of the trainee's experience and providing safe and appropriate patient care.1 Clinical supervisors also have a broader role in ensuring the wellbeing of students and trainees.

1.4 Medical training in Australia follows rigorous, independently determined standards that require trainees to work in accredited, supervised training positions to gain the experience they need to practise as safe, competent, and independent practitioners. Supervision must also meet the Australian Medical Council (AMC) standards for accreditation.

1.5 The AMA supports the traditional apprenticeship model of training, which is patient-centred and skills-based. This typically involves supervisors demonstrating appropriate skills, abilities, and attitudes in the clinical environment, and enables trainees to be directly involved in patient care.2

1.6 Patient care provided during clinical training must be safe, of a high quality and clinically appropriate. This includes ensuring that trainees are maintaining safe working hours, and appropriate and transparent supervision processes and consistent standards are in place across a diverse range of settings to ensure that the quality and safety of medical practice in maintained.

1.7 Good supervision is most likely to occur when both the supervisor and trainee are clear about their respective roles and responsibilities, particularly with regard to patient care. This includes being clear about how supervision will occur, who will provide direct supervision and training, and who will hold overall responsibility for overseeing the trainee's placement.

[1] Kilminster SM, Jolly BC, Grant J, Cottrell DJ. Good supervision: guiding the clinical educator of the 21st century. Report to the Department of Health. Sheffield: University of Sheffield, 2000.
[2] AMA position *statement Supervision and assessment of hospital based postgraduate medical trainees 2012*.

1.8 Trainees should not be placed in a position where they are not adequately supported by senior medical staff. It is vital that trainees are adequately supported where they undertake placements with minimal on-site supervision. This can include specific preparation and training prior to the placement, briefing on the likely clinical problems and situations trainees will encounter, use of telehealth to communicate with senior doctors and other members of the supervising team, and/or regular debriefing and mentoring. It is imperative that the practical application of these supports are externally regulated and reviewed with inbuilt safety processes such that trainees can feedback on issues anonymously.

2. Investing in supervision capacity

Public sector

2.1 Australia is fortunate that many clinicians choose to work in the public health sector to serve the community and train the next generation of doctors. Though the numbers of trainees are increasing rapidly, the number of supervisors in our public hospitals has remained relatively static. There is an ongoing tension between the demand for service delivery and the need to train and supervise trainees. Feedback from our members indicates that there is also insufficient recognition of, and support for, the teaching and training that doctors provide in public hospitals.

2.2 The AMA believes that increased investment in supervision capacity and supporting infrastructure in public hospitals is needed to sustain the medical workforce. The quality of medical training will be eroded if investments in clinical supervision and supporting infrastructure fail to keep pace with the growth in trainee numbers. Health systems must commit to provide the human and financial resources necessary to provide effective supervision to ensure that the quality of medical education and training in Australia remains at a high standard. This includes committing to improved subsidy arrangements to attract more supervisors to medical training.

2.3 The AMA supports a funding model that separates teaching and training and recognises that these activities occur alongside service delivery and enhances patient care. A separate funding stream for teaching and training also contributes to an improved educational culture in institutions.

2.4 The allocation of funding should be made based on explicit and transparent criteria and processes. Performance benchmarks must be developed and agreed upon by all levels of government to measure achievement against teaching and training commitments in health services.

Expanded settings

2.5 Medical training in expanded settings is now an important adjunct to the public teaching hospital model and must be adequately resourced to meet increased training demands and changes to services delivery. This includes resources for professional support and access to educational resources for supervisors. It is important that training posts involve appropriate service provision and trainees, where possible, have the same opportunities to participate in procedural work as their colleagues in the public system.

2.6 Given that exposure to private practice and private hospitals is a now an important component of vocational training the AMA believes the Commonwealth should increase funding to the private sector (e.g., via the Commonwealth Specialist Training Program) to boost supervisor capacity and ensure safe and supported supervision of doctors training within the private health sector.[3]

General practice

2.7 General practice is the cornerstone of successful primary health care. Funding arrangements must support general practitioners and other medical practitioners who are involved in the teaching of medical students and doctors in general practice to undertake this role. This applies equally to doctors who are supervising general practice trainees in other speciality settings.

Regional and rural settings

2.8 The Commonwealth Government must provide funding to support rural general practice training including well-designed infrastructure grants to help rural general practitioners to provide additional consultation rooms, and space for teaching medical students and supervising trainees. Similarly, rural hospitals must be funded by state governments to develop modern facilities to provide an environment that is conducive to delivering a strong and relevant training experience for medical students and trainees with the appropriate level of supervision.

2.9 Consideration also needs to be given as to how alternative models of supervision could provide greater flexibility in establishing training pathways to meet the needs of communities outside of metropolitan centres while continuing to meet training program requirements and accreditation standards. The development of functional links between regional training networks and existing training infrastructure is integral to this.

International medical graduates (IMGs)

2.10 IMGs often work in positions in rural and remote Australia that are isolated, and in locations where access to appropriate resources, supervision and mentoring may be difficult. This may hinder their ability to function effectively as well as participate in up-skilling and continuing professional development programs.

2.11 It is critical that IMGs and supervising practices have access to adequate resources to provide the necessary supervision to support IMGs. Medical Colleges and other accredited training providers must ensure appropriate (remote) supervision arrangements and distance learning tools where required are in place to assist IMGs in rural and remote locations to develop their skills on an ongoing basis, and as far as possible, deliver skills assessment programs in the workplace.

3. Supporting doctors who supervise

[3] In 2011, the Commonwealth amended the health insurance regulations to allow supervisors to bill Medicare for procedural services undertaken by a specialist trainee under their direct supervision.

3.1 Supervision is a skill that requires training, development, and support. Supervisors should be trained in the process of supervision and provided with funding, time, and resources to support them to attend professional development courses to assist them to develop skills in clinical supervision and support, leadership, and teamwork.

3.2 Supervisors should also be trained in how to give and receive feedback, monitoring and responding to trainee wellbeing, unconscious bias, cultural safety, and how to monitor for, and respond to disclosures of bullying/harassment. Teaching competencies should be included in the professional development plans of all trainees.

3.3 To give clinical supervisors the time they need to train the next generation of doctors, they need access to protected time for teaching and training. Despite this, feedback from supervisors and trainees shows that clinical support time in the public hospital system is not being adequately recognised or supported. This includes doctors being actively discouraged from quarantining time for teaching and training activities. Inadequate clinical support time arrangements also increase the risk of burn-out among supervisors who balance the time pressures of supervision and medical practice.

3.4 The AMA recommends doctors should be allocated at least 20 per cent of their normal weekly hours to clinical support time duties, consistent with medical college guidelines where relevant.4 Clinicians with formal management responsibilities as head of department or in other senior roles, and those who are supervisors of training, should have an additional allocation of time for these responsibilities. The AMA recommends Unit Heads (and above with management roles) should be provided with a minimum 50 per cent clinical support time allocation. Specific funding must be made available to support the provision of protected training time in the public hospital system.

3.5 The AMA supports the development of professional standards and competencies for clinical supervision to the extent that they teach broad educational principles and the skills to apply these into the workplace. They should include skills in broader responsibilities for supervisors such as mentoring, personal development, and cultural safety. Standards and competencies must be flexible enough to account for different skill acquisition, and be relevant and consistent across the medical education continuum. They should not be overly prescriptive and must meet the relevant AMC standards for accreditation.

3.6 Doctors in training such as interns, residents and registrars need to be meaningfully supported in their roles as mentors, teachers and facilitators in formal and informal training environments to medical students and other doctors in training.

3.7 Specialists who are providing clinical supervision in private and community settings to encourage training in these settings and increase overall supervisory capacity must be provided with appropriate administrative support and remuneration.

4. Fostering a culture within medicine that encourages teaching and training

[4] https://www.ama.com.au/position-statement/clinical-support-time-public-hospital-doctors-2010-revised-2019

4.1 The AMA encourages medical practitioners to display a professional commitment and engage in the teaching and training of others and supervising the work of less-experienced colleagues. This is an important part of sustaining the profession and delivering high-quality patient care.

4.2 The AMA supports formal recognition of supervisors by medical colleges and health systems and awarding doctors who have made significant contributions to clinical supervision and training. This could be achieved by recognising supervision as part of continuing professional development.

4.3 All trainees should have the opportunity to provide detailed feedback on their training experience during each term, and, when appropriate, to provide their supervisors with constructive feedback without fear of professional or personal consequences. Continuous evaluation and improvement in modern medical education requires institutions and programs to empower trainees to safely give feedback including anonymous program feedback regarding their supervision and training programs.

4.4 The AMA also encourages the development of mentoring frameworks that increase the access of junior doctors to unbiased mentors outside of the immediate workplace, if desired. Formal and informal mentoring programmes can help trainees enhance support structures, build a sense of community, and navigate new professional environments. A mentor should not be involved directly with supervision or assessment. The AMA recognises that trainees may still feel vulnerable voicing concerns to mentors who work within the same department as their supervisors or potential referees. The AMA also supports the professional development of doctors who have a demonstrated interest and enthusiasm for mentorship.