AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA submission on the review of the Supervised Practice Framework

Introduction

Supervision is a skill that requires ongoing training, development, and support. Supervisors should receive formal training in supervisory practices and be provided with adequate funding, time, and resources to develop their skills in clinical supervision. Supervisees must be equipped with the necessary resources to meet their requirements and should be fully supported throughout their supervisory journey. The Australian Medical Association (AMA) takes this opportunity to acknowledge the work Ahpra and the Medical Board of Australia have undertaken in developing and refining the Supervised Practice Framework. The AMA supports improvements that make the framework clearer, more robust, more flexible and easier to understand.

Which option do you support?

The AMA supports updating the Supervised Practice Framework with the feedback provided below.

The AMA supports a framework that is contemporary and reflects best practice for supervision in the interests of public safety.

What is your experience with the Supervised Practice Framework? What parts of the framework are working well?

The current process for assessing applications under the Supervised Practice Framework has, at times, been inefficient. AMA members have reported that assessments are conducted incrementally, and when issue are identified, applicants are asked to make corrections, which can take several weeks to be processed. Only once these corrections are addressed does the assessment proceed to the next section, repeating the cycle. This approach delays outcomes. In one instance, it was reported an application took eight months to complete, despite the candidate having already successfully progressed through the RACGP process. Such inefficiencies place unnecessary strain on both applicants and supervisors, and hinder timely workforce integration. The AMA urges greater consistency in assessment timelines, along with the implementation of streamlined, efficient and supportive administrative processes.

Could the framework be improved or simplified?

The AMA's view is the framework must be a robust and comprehensive document that outlines all the necessary elements relating to supervision. The AMA remains engaged in this consultation process and looks forward to commenting on a draft revised framework when released for consultation.

Direct supervision presents significant challenges in rural settings. The current model is economically viable primarily in large metropolitan hospitals, where resources and staffing levels can accommodate the intensive supervision required. In contrast, smaller practices and rural health services often lack the infrastructure and funding to support direct supervision — despite being areas of high workforce need.

It is important that the framework incorporates robust quality assurance mechanisms to ensure consistent supervision experience, meet required standards, and integrate the expertise of seasoned supervisors in shaping and delivering supervision.

The intention of the framework was to allow individual flexibility regarding the levels of supervision and changes to supervisors/supervision levels or practice settings depending on the circumstances of the supervisee. Do you believe the framework is working as it was intended?

While the AMA supports flexible supervision — particularly in rural, regional, and remote contexts — we note potential challenges when non-doctors are involved in providing supervision for doctors. The AMA does not support interprofessional supervision, particularly with four National Boards using profession-specific guidelines for supervised practice.

Currently, there are four levels of supervision – Direct, Indirect 1 (present), Indirect 2 (accessible), and Remote. Are all four supervision levels working effectively to keep the public safe?

The AMA has received feedback indicating that progression between levels of supervision is challenging. Furthermore, direct supervision poses significant difficulties for rural and remote health practitioners, as there are few safeguards in place to ensure it consistently occurs.

Under the current framework, remote supervision (via phone or teleconferencing) is not available for Direct or Indirect 1 (present) supervision levels. Can practitioners complete supervised practice and be supported via remote supervision, including those located in rural and remote areas who are required to complete Direct and/or Indirect 1 (present) supervision, whilst also ensuring safe practice?

In the rural and remote context, the Supervised Practice Framework has faced criticism for their rigid application of supervision levels, often disregarding the nuanced insights provided by experienced supervisors. A more collaborative approach — where Ahpra actively listens to and considers supervisor recommendations — could enhance the framework's responsiveness and better align it with real-world clinical practice.

Strong consideration must be given to encouraging and developing innovative remote models of supervision, particularly for healthcare professionals residing and working in rural, regional, and remote contexts. These models could include direct daily supervision by a senior doctor or fellow

from a differing specialty, accompanied by regular check-ins and the on-call availability of a remote, specialty-specific supervisor.

Is the framework and its appendices clear in the information for and expectations of supervisees, supervisors and employers? Why/why not? If not, what would improve this information?

Broadly, the sections outlined above are appropriate and include the relevant information needed to outline expectations.

The AMA suggests improvements in relation to supporting supervisors. 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 supervisees.

To give clinical supervisors the time they need to train the next generation of healthcare professionals, they must have access to protected time for teaching and training. Despite this, feedback from supervisors and supervisees shows that clinical support time — specifically in the public hospital system — is not being adequately recognised or supported. This includes instances where doctors are actively discouraged from setting aside dedicated time for teaching and training activities. Inadequate arrangements for clinical support time also increase the risk of burn-out among supervisors, who balance the demands of supervision and with their medical practice.

To ensure effective implementation of Ahpra's Supervised Practice Framework, supervisors must allocated adequate time to engage with and understand the supporting materials, including Appendices 2, 3, and 5. Member feedback has highlighted a significant concern regarding the practical constraints faced by supervisors, who are often concurrently engaged in clinical duties. Given the time pressures inherent in medical practice, there is a need to acknowledge and address the limited capacity of supervisors to thoroughly review these appendices. Consideration should be given to streamlining access to key information and providing flexible, time-efficient resources to support supervisors in fulfilling their responsibilities under the framework.

How well does the framework and supporting documentation contribute to protecting patients and ensuring public safety?

No comment.

Have you received any feedback from patients and consumers about their experience of practitioners who are under supervised practice?

No comment.

Other comments and feedback

The supervised practice plan

To support the effective implementation of Ahpra's Supervised Practice Framework, it is critical that Ahpra publishes clear, acceptable examples of the supervised practice plan. Member feedback consistently identifies this section as the most confusing part of the application process. Supervisors often lack guidance on what constitutes an acceptable submission, leading to uncertainty and inconsistency in assessments. What is deemed acceptable by one assessor may be rejected by another, resulting in a process that feels arbitrary and reliant on guesswork. Standardised examples and clearer criteria would enhance transparency, reduce administrative burden, and improve confidence in the framework's fairness and reliability.

Independence in supervision assessments

To uphold the integrity of the supervised practice process, consideration could be given to involving external practitioners in the assessment of supervised practitioners. Feedback has raised concerns about potential conflicts of interest when assessments are conducted by practitioners within the same practice, who may have a vested interest in endorsing their colleagues. An independent assessment model would strengthen objectivity, ensure public safety, and align with the principles of impartiality and accountability.

A comprehensive review of the supervision system is necessary to address these structural issues and enable the framework to be implemented effectively and consistently across diverse practice settings.

Internationally qualified practitioners

In the context of internationally trained professionals who have 'general' or 'specialist' registration with Ahpra and may be required to complete a period of supervised practice — either (a) to meet registration requirements (e.g., recency of practice) or (b) as part of a board-imposed condition or undertaking — the AMA note there must be access to dedicated supervisors and mentors who understand the challenges faced by internationally trained professionals. Peer support networks are also important for sharing experiences and advice. This support helps these practitioners navigate their new roles more effectively and feel more integrated into the professional community.

Contact

president@ama.com.au