Supervision and assessment of hospital based postgraduate medical trainees

2012

1. Introduction

1.1. Medical training in Australia follows rigorous, independently determined standards that require prevocational and vocational trainees (trainees) to work in accredited, supervised training positions to gain the experience they need to practise as safe, competent, independent practitioners.

1.2. 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 allows trainees to be directly involved in patient care.

1.3. Maintaining quality clinical supervision and assessment represents a significant challenge for the medical profession. Increasing numbers of medical graduates, the demands of service delivery and changing funding models in public hospitals are straining the capacity of clinicians to undertake teaching and training. In 2006, only 20% of medical practitioners with a primary clinical occupation reported providing some medical education. Private-sector settings and community settings are being increasingly used for training, but the mechanisms to support and recognise teaching by clinicians varies significantly between sites.

1.4. While generic models of inter-disciplinary clinical supervision may be proposed as a strategy to address training capacity, there are distinct elements of medical training that preclude the widespread use of such models. Generic models of supervision are effective at a basic level only, as medical training quickly becomes more intense, detailed and focussed compared to other health disciplines. The AMA recommends a cautious approach to implementing models of inter-disciplinary clinical supervision to postgraduate medical education and training.

1.5. The unique nature of, and high degree of certification involved in, medical education and training heightens the importance of high quality supervision, training and assessment across the continuum of medical training.

1.6. Achieving high quality supervision and assessment of medical trainees must be a high priority for the health system. Effective supervision develops medical professionalism and contributes to improved patient safety, better health outcomes and faster acquisition of skills by trainees.

1.7. This document outlines the AMA position on supervision and assessment of trainees to ensure the quality of medical education and training remains of a high standard. It should be read in conjunction with other relevant AMA position statements listed at the end of this statement.

---

1 Catherine M Joyce, Leon Piterman and Steven L Wesselingh. The widening gap between clinical, teaching and research work. MJA 2009; 191 (3): 169-172.
3 Catherine M Joyce, Leon Piterman and Steven L Wesselingh. The widening gap between clinical, teaching and research work. MJA 2009; 191 (3): 169-172.
2. Structures supporting effective supervision and assessment

2.1. The AMA supports the critical role of postgraduate medical councils (PMCs) [and their equivalents] and medical colleges in contributing to the quality of medical training by supporting the supervision and assessment of trainees through rigorous training standards, assessment and feedback mechanisms. Along with employing institutions, they are responsible for ensuring the necessary training structures are in place to support supervisors and trainees. Trainees should be involved in the governance structures of both PMCs and the medical colleges.

2.2. Regular review of supervision and assessment frameworks by each medical college is important if the quality of specialty training is to be maintained in the face of escalating trainee numbers. They must have a firm foundation in educational theory, and be consistent with contemporary best practice in workplace based teaching and learning.

2.3. The AMA recognises the important role of the Australian Medical Council (AMC) in independently setting accreditation standards for undergraduate and specialist medical education. This should be consistent with the requirements of the World Federation for Medical Education. The AMA sees merit in an accreditation framework that spans the continuum of medical education, and therefore supports AMC accreditation of PMCs against agreed benchmarks. The AMC must be allowed to do this in an environment that is free from political interference and sectional interests.

2.4. Teaching hospitals should ensure medical training remains a key priority by employing and empowering an appropriately qualified Director of Clinical Training (DCT). This includes providing the necessary infrastructure and administrative support to allow the DCT to carry out their role efficiently and effectively. Medical Education Officers (MEO) should also be supported, particularly to support prevocational trainees. The AMA recognises the different but complementary roles undertaken by DCTs and MEOs to ensure high quality patient care by guiding and supporting trainees. The DCT-MEO team enhances the profile of medical education and training within a hospital and helps to maintain the balance between clinical training experience, workload and training opportunities to enhance supervisor and trainee development and performance.

2.5. DCTs fulfil an essential role in teaching hospitals by providing support, supervision and counsel to trainees. In addition to their usual hospital commitments, DCTs are responsible for defining the education, supervision and career development needs of trainees, identifying and addressing the special needs of some trainees, encouraging consultants and registrars and other educators to supervise and educate more junior doctors in all aspects of patient care, providing trainees with appropriate feedback and ensuring that term descriptions are in place. The AMA supports strengthened roles for DCTs, including their involvement in governance and key decision making processes.

2.6. MEOs work with senior medical staff responsible for the supervision and education of trainees to advocate for and enhance teaching and learning opportunities for trainees. They contribute to the monitoring and improvement of the quality of supervision, feedback and teaching of trainees and provide support to supervisors as well as trainees.

---

3. Supervision

3.1. Effective clinical supervision is a vital part of postgraduate medical education. Evidence suggests that when provided effectively, supervision not only improves trainees' performance, but also improves patient outcomes.\(^8\)

3.2. It has been recently defined as ‘the provision of guidance and feedback on matters of personal, professional and educational development in the context of the trainee's experience and providing safe and appropriate patient care'.\(^9\) The AMA supports the use of the term ‘clinical supervisor’ for supervision in the context of caring for patients while being involved in the teaching, supervision and assessment of clinical work. For interns and residents within the public hospital sector, most direct clinical supervision is provided by registrars, with consultants providing oversight and support.\(^10\)

3.3. It is conceivable that the quality of medical training could be eroded if investments in clinical supervision and supporting infrastructure fail to keep pace with the growth in trainees. Health systems must commit to provide the human and financial resources necessary to provide effective supervision. The AMA recommends that a series of key performance indicators be developed as a matter of urgency to support quality outcomes in clinical supervision and training across the supervision pathway. These should be both quantitative and qualitative and include process measures such as supervision levels, and outcome measures such as the results of assessments.\(^11\)

3.4. At a practical level, 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.

3.5. Trainees should not be placed in a position where they are not adequately supported by senior medical staff. The AMA believes this is more likely to occur in more remote settings and has the potential to harm the professional development of trainees and increases the risk of adverse events. 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, regular debriefing and mentoring.

3.6. The AMA recognises that, from an educational perspective, there is merit in encouraging an environment that builds on the relationships between consultants, vocational and prevocational trainees. The introduction of designated medical education registrar officers\(^12\) can support the training and supervision of more junior doctors by providing a basis for consistent supervision, support and tutelage. Anecdotal evidence suggests that junior doctors also improve their supervisory and teaching skills from undertaking these types of posts. The AMA encourages further funding to enable an expansion of medical education registrar posts, as well as research into other innovative models in clinical supervision.

---

\(^11\) BMJ 2011; 342.
3.7. Mentoring can be a useful adjunct to clinical supervision where an experienced, highly regarded person guides and encourages trainees in their careers, usually over a longer period than the standard clinical rotation, and who confidentially discusses difficult issues with trainees. Ideally, a mentor should be chosen by the trainee and not be involved directly with supervision or assessment. The AMA recommends that organisations develop processes for supporting the professional development of doctors who demonstrate an enthusiasm for mentoring.

3.8. Supervisors should be trained in the process of supervision and provided with time and resources to attend professional development courses to assist them develop supervisory and teaching skills. Courses such as ‘Teaching on the Run’, the ‘Professional Development Program for Registrars’ and ‘Essential Skills in Medical Education’ are valuable in providing additional skills in clinical supervision and support, leadership and teamwork to clinicians to improve the quality of education supervision provided to trainees. Teaching competencies should be included in the professional development plans of all trainees.

3.9. The AMA supports the development of professional standards and competencies for clinical supervision. Such 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. The AMA acknowledges the work of organisations in international settings (such as the Academy of Medical Educators in the United Kingdom) in defining and achieving high standards in teaching of medical educators, educational supervisors and trainers that will lead directly to higher quality patient care.

3.10. Supervisors will increasingly be required to supervise trainees across a variety of non-traditional settings, including the private sector and simulated learning centres. Professional support must be provided to supervisors who train in these new settings, along with access to educational resources and applications for grants.

3.11. Employing hospitals can demonstrate a commitment to clinical supervision and training by giving greater recognition and support to the supervision and training roles undertaken by clinicians. The AMA supports a range of measures, rewards and incentives that, in a transparent and fair manner, give appropriate recognition to the contribution made by clinical supervisors. These include:

(a) recognition of supervision and teaching responsibilities in registrar and consultant work plans;
(b) liaison with supervisors regarding the implications for clinical service delivery;
(c) funding to enable doctors to be released from their clinical service roles;
(d) the provision of appropriately qualified staff to temporarily backfill positions;
(e) quarantined and remunerated time from service delivery for training and teaching in addition to, and separate from, personal and professional development time;
(f) a nationally consistent scheme for giving professional credit for attaining medical education qualifications and delivering training; and
(g) formal recognition of outstanding educators and supervisors by the medical colleges.

3.12. The AMA has a benchmark for quarantined clinical support time, which includes supervision, teaching and training. This benchmark specifies that at least 30% of a public hospital senior

---

16 Academy of Medical Educators. Professional support for medical educators. 2011.
http://www.medicaleducators.org/aome/index.cfm/profession/
clinician’s time should be set aside for clinical support work.\textsuperscript{18} This must be an explicitly recognised part of the funding arrangements to support supervision training in public hospitals and should include funding for the provision of appropriately qualified staff to temporarily backfill positions. The AMA advocates that this benchmark form part of accreditation processes performed by the PMCs, colleges, the Australian Council on Healthcare Standards and other relevant organisations.

4. Assessment

4.1. Assessment is one driver of learning and it is critical that workplace-based assessment processes, including examinations, are relevant to clinical practice.\textsuperscript{19} Assessment and feedback processes should aim to optimise the capabilities of all trainees by providing motivation and direction for future learning with the goal of producing doctors who are safe, competent, independent practitioners.\textsuperscript{20}

4.2. It is suboptimal to rely on a single assessment tool as the basis for limiting or allowing the progression of a trainee. A rigorous, multi-source system of assessment and feedback, appropriate to the particular level of medical training, are essential components of medical training programs. Assessment methods should measure and provide feedback on the trainee’s knowledge, clinical skills, professional qualities and expertise for safe and competent practice at an appropriate standard.

4.3. Supervising clinicians’ observations and impressions of trainees over specific periods remain the most common tool used to assess and evaluate trainee performance.\textsuperscript{21} It is essential that the purpose and expectations of each assessment are clearly articulated at the beginning of the training program including:

(a) the major focus and goals of the placement and expectation of the trainee’s role;
(b) placement learning objectives and skills training goals; and
(c) supervision needs and the process of assessment.\textsuperscript{22,23}

Trainees should be provided with clear expectations about the assessment process and have some control over, and input into, the process.\textsuperscript{24}

4.4. The Australian Curriculum Framework for Junior Doctors (ACF) provides clear direction as to the key skills that junior doctors should acquire in the early postgraduate years. It should be used as a platform to formatively assess trainee performance in the workplace and to measure outcomes. Supervisors should use the ACF to guide the setting of appropriate trainee goals for the term they are supervising. Assessment against the ACF should not be onerous.

4.5. Self-assessment by trainees is encouraged and provides a basis for discussing progress and the future direction of training. Skills in self-assessment are now an integral part of professional development and are required in most vocational training programs.\textsuperscript{25}

\begin{itemize}
\item \textsuperscript{19}Australian Medical Association. 2010 AMA Specialist Trainee Survey. Canberra: AMA, 2011.
\item \textsuperscript{20} Epstein R. Assessment in Medical Education. \textit{N Engl J Med} 2007; 356:387-396.
\item \textsuperscript{21} Epstein R. Assessment in Medical Education. \textit{N Engl J Med} 2007; 356:387-396.
\item \textsuperscript{22} NSW Institute of Medical Education and Training. Assessing prevocational trainees: a brief guide for Term Supervisors. NSW Health.
\item \textsuperscript{23} Australian Medical Council. Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures. Canberra: AMC, 2010.
\item \textsuperscript{24} Craig T Hore, William Lancashire and Robert G Fassett . Clinical supervision by consultants in teaching hospitals. MJA 2009; 191: 220-222.
\item \textsuperscript{25} NSW Institute of Medical Education and Training. Assessing prevocational trainees: a brief guide for term Supervisors. NSW Health.
\end{itemize}
4.6. ‘Feedback’ refers to the giving of information describing a doctors’ performance in an observed clinical situation. It can be both formal (regular and covering term outcomes) and informal (daily). Providing specific, constructive and regular feedback to trainees in a way that is useful for them to consider and use to improve their future performance plays an essential role in learning and professional development in medicine. Supervisors must be supported to provide constructive feedback to trainees, and to respond appropriately to their concerns.

4.7. Clear processes must be in place to confidentially address student and trainee problems with assessment processes, and to provide for disputes and appeals in timely manner. Best practice models of appeals processes characteristically ensure natural justice, have clear processes and criteria and seek to avoid the potential for litigation. It is critical that colleges strive to operate appeals processes that conform to these principles.

4.8. Assessment must be longitudinal and ensure the early identification of trainees who are under performing and for transparently determining programs of remedial work.

4.9. Continuous evaluation and improvement in modern medical education requires trainees to give feedback on their supervision and training programs. Despite this it can often be difficult to obtain anonymous program feedback from trainees who fear being identified. 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.

4.10. Appropriate appeals processes should be in place to allow trainees to have their assessment reviewed.

5. Resourcing effective supervision and assessment

5.1. An appropriate amount of funding must be dedicated to clinical supervision if the high standard of medical education and training in Australia is to be maintained. The AMA calls on Federal and State Governments to reach agreement on the number of quality prevocational and vocational medical training places needed and to ensure that sufficient infrastructure and clinical resources are directed to training prevocational and vocational trainees. This includes an agreement on improved subsidy arrangements to attract more supervisors to become involved in medical training.

5.2. Robust performance benchmarks must also be developed and agreed upon by all levels of government to measure achievement against teaching and training commitments, with the Medical Training Review Panel (MTRP) to monitor and report on progress against these targets.

5.3. The AMA calls on the Commonwealth to develop, in consultation with the profession, performance benchmarks that would be monitored by the MTRP and the National Health Performance Authority to ensure that the quality of medical training is sustained.

See also:


AMA Position Statement. Medical training in expanded settings including the private sector. 2007

Reproduction and distribution of AMA position statements is permitted provided the AMA is acknowledged and that the position statement is faithfully reproduced noting the year at the top of the document.