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**Project contact details**

Kevin Forsyth; Program Director
Kevin.forsyth@clinicaleducators.org

Andrea Lloyd; Educational Development Manager
Ph: +61 8 8313 1458
andrea.lloyd@clinicaleducators.org

Alison Jones; Academic consultant
Alison.jones3@health.sa.gov.au

Web: www.clinicaleducators.org

# A Framework of Professional Activities for Supervisors

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19. Cate Ot. Trust, competence, and the supervisor's role in postgraduate training. BMJ. 2006;333 (October):748-51.

20. Norcini JJ BL, Arnold GK, Kimball HR. . The mini-CEX (clinical evaluation exercise): a preliminary investigation. Anals of Internal Medicine. 1995;Nov 15; 123(10):795-9.

21. Southgate L, Cox J, David T, Hatch D, Howes A, Johnson N, et al. The General Medical Council's Performance Procedures: peer review of performance in the workplace. Medical Education. 2001;35:9-19.

22. Mainwairing A, Nesargikar P, Clark G. Observed workplace based assessments: Need for observation! International Journal of Surgery. 2011;9(7):568.

23. Wragg A, Wade W, Fuller G, Cowan G, Mills P. Assessing the performance of specialist registrars. Clinical Medicine, Journal of the Royal College of Physicians. 2003;3(2):131-.

24. Morris A, Hewitt J, Roberts CM. Practical experience of using directly observed procedures, mini clinical evaluation examinations, and peer observation in pre-registration house officer (FY1) trainees. Postgraduate Medical Journal. 2006;82(966):285-8.

25. Pace E and Orton V (2004) Early signs of the trainee in difficulty. *Hospital Medicine.* **65;** 238-40

26. Hesketh EA and Laidlaw JM, (2002) Developing the teaching instinct - Feedback. *Medical Teacher* Vol 24, No 3, 245-248.

27. Dudek NL, Marks MB, Regeher G. (2005) Failure to fail: perspectives of clinical supervisors. *Acad Med* 2005; 80:S84-7.

28. Hodges B et al; Assessment of Professionalism : Recommendations from the Ottawa 2010 Conference. Available at http://repository.up.ac.za/bitstream/handle/2263/19750/Hodges_Assessment(2011).pdf?sequence=1

29. Kabat-Zinn, Jon Coming to our senses; 2005; New York; Hyperion.

30. Epstein RM. Mindful practice. Journal of the American Medical Association 1999;282:833-8.

31. Epstein RM. Mindful practice in action (I): technical competence, evidence-based medicine, and relationship-centered care. Families, Systems & Health. 2003;21(1):1+.

32. Epstein RM. Mindful practice in action (II): cultivating habits of mind. Families, Systems & Health. 2003;21(1):11+.

33. Kolb DA. Experiential learning: Experience as the source of learning and development. New Jersey: Prentice-Hall; 1984.

## REFERENCES


1. Kilminster SM, Jolly BC. *Effective supervision in clinical practice settings: a literature review*. Medical Education. 2000;34(10):827-40.
2. Launer J. Supervison, *Mentoring and coaching*. In: Swanwick T, editor. Understanding Medical Education; Evidence, theory and practice. London UK: Wiley-Blackwell; 2010. p. 111-23.
3. Halpern H, McKimm J. *Supervision*. Br J Hosp Med. 2009;70(4):226-9.
4. Kennedy TJTL, Lorelei; Baker, G Ross; Kitchen, Lisa; Regehr, Glenn *Clinical oversight Conceptualising the relationship between supervision and safety*. Journal of Internal Medicine. 2007;22((8) bAug).
5. Gupta RaL, S. *Mentoring for Doctors and Dentists.* Oxford: Blackwell; 2000.
6. Farnan JM, Petty, L. A., Georgitis, E., Martin, S., Chiu, E., Prochaska, M. and Arora, V. M. *A Systematic Review: The Effect of Clinical Supervison on Patient and Residency Education Outcomes*. Academic Medicine. 2012;87(4 April).
7. Kilminster S, Cottrell D, Grant J, Jolly B. AMEE Guide No. 27*: Effective educational and clinical supervision.* Medical Teacher. 2007;29(1):2-19.
8. CET*I*. *The Superguide: a handbook on supervising doctors in training*. In: CETI, editor. Sydney2010.
9. Kennedy TJT, Regehr G, Baker GR, Lingard L. *Point-of-Care Assessment of Medical Trainee Competence for Independent Clinical Work*. Academic Medicine. 2008;83(10):S89-S92 10.1097/ACM.0b013e318183c8b7.
10 . Norcini J, Burch V. *Workplace-based assessment as an educational tool*: AMEE Guide No. 31. Medical Teacher. 2007;29(9-10):855-71.
11. Lake FR, Gerard. *Teaching on the run; teaching tips for busy clinicians*. Pyrmont NSW: MJA Publishing; 2007.
12. Wall D. *Evaluation: improving practice, influencing policy*. In: Swanwick T, editor. Understanding Medical Education: Evidence, theory and Practice. West Sussex: Wiley-Blackwell; 2010.
13. Cantillon P, Sargeant J. *Teaching Rounds: Giving Feedback in Clinical Settings*. BMJ: British Medical Journal. 2008;337(7681):1292-4.
14. Morris C. Facilitating learning in the workplace. Br J Hosp Med. 2010;71(1):48-50.
15. Lave JW, E. Situated Learning: Legitimate Peripheral Participation. Cambridge UK: Cambridge University Press; 1990.
16. Walker MP, JWR. Teaching in theatre. In: Peyton J, editor. Teaching and Learning in Medical Practice. Rickmansworth, UK: Manticore Europe Limited; 1998. p. 177-80.
17. Peyton J. The learning cycle. In: JWR P, editor. Teaching and learning in medical practice. Rickmansworth, UK: Manticore; 1998. p. 13-9
18. Miller G.E . *The Assessment of Clinical Skills/Performance*. Academic Medicine . (Supplement) 1990; 65; S63-7.


## Overview of Supervision

The verb *supervise* has origins in the Latin word *supervidere*, from *super-*, meaning "over" and *videre*, meaning "to see." Therefore, in simple terms, *supervision* is the act of *overseeing;* usually another, more junior, person's work. Kilminster and Jolly (2000) defined supervision as:

> "*The provision of guidance and feedback on matters of personal, professional and educational development in the context of a trainee's experience of providing safe and appropriate care."(1)*

In the clinical setting *supervision* performs many functions. It can monitor a person's performance to ensure they are working safely and within the scope of their abilities. The process of supervision can also aid in establishing benchmarks and expectations as well as providing instruction and support in meeting them. Additionally, supervision may assist in establishing the supervisee's learning needs and ongoing professional and educational development.

**Benefits of supervision**

The benefits of good supervision are reported widely in the literature and principally relate to improved patient safety (1, 4, 6, 7) and enhancing the educational development of the trainee (1-3). However, it has also been shown that supervising has a positive effect on the supervisors themselves by increasing job satisfaction (8) as well as on team dynamics.

As Launer reports(2), some controversy surrounds whether the act of supervision is principally about safety and standard setting or about the professional development of the trainee. Although on occasions there may be 'conflict' between these two supervisory activities, both are required.

**Patient safety**

There is evidence in the literature (6, 7) that effective supervision or oversight has an impact on safe and quality care. All senior clinicians responsible for patient care with junior doctors providing most of that day-to-day care are concerned about the clinical competence of their junior doctors. The safety of their patients, and the quality of clinical care, is critically dependent on such clinical competence of junior doctors. Supervision of these junior doctors, and the extent to which the consultant needs to be hands-on and intervene, versus allowing space for the junior doctors to take patient responsibility and learn on the job, is a challenge. Clinical oversight, and skills in providing supervision for clinical oversight, needs to be in the domain of every consultant.

**Educational development of trainees.**

For the trainee, the opportunity to put knowledge into practice and refine their skills through clinical training in the real world provides them with the link from study to future independent practice. It is through situated, authentic experience that they learn the craft of medicine. Amongst the array of clinical experience, supervisory support to assist them clarify learning goals and learning opportunity from their clinical experiences enriches their training, scaffolds their learning, and provides structure to guide them along a learning path from novice to expert.

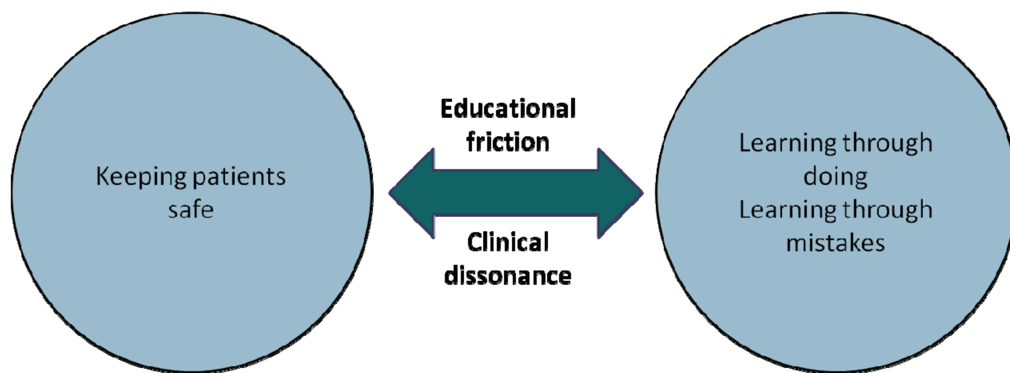



*Fig 1: The tension of clinical training*

## Mindful Practice

1. Which of the following are requirements for mindfulness?

- ☐ expert topic knowledge
- ☐ attentive observation
- ☐ critical curiosity
- ☐ high-level clinical skills
- ☐ a 'beginners' mind
- ☐ Presence

2. Which of the following are aspects of mindful practice?

- ☐ Reflective questioning
- ☐ Keeping to time on appointments
- ☐ Attentive listening

3. Make a note of things you do or could try to do to promote mindfulness in your practice.

## Professional Development

1. What is meant by the 'Hidden Curriculum'?

- ☐ Information found in texts which is not assessed in exams.
- ☐ Information learnt in tutorial groups from peers
- ☐ The unspoken 'ways of working' in the clinical setting.

2. The guidance and counsel provided by a more senior colleague, often in relation to professional development and career progression, is known as:

- ☐ Mentoring
- ☐ Coaching
- ☐ Oversight

3. When do most trainees make a decision regarding their specialty choice?

- ☐ Upon entering medical school
- ☐ In the first 1-2 years following graduation
- ☐ In final year of medical school

### Supervision in the Clinical Environment

The role of supervisor is pivotal in the 'master and apprentice' model of clinical learning that has underpinned medicine from its earliest beginnings. The clinical environment permits medical trainees to put into practice the knowledge gained in the academic environment and refine their clinical skills; it provides for situated and authentic learning, facilitates socialisation into the profession and creates opportunity for role modelling by more senior colleagues..

At times the learning in this environment can be serendipitous or opportunistic at best but via mutual goal setting of learning objectives with a clinical supervisor, a roadmap for ongoing clinical competency may be developed. The trainee is on a journey of professional development which requires them to meet their learning needs whilst ensuring safe, quality patient care. Good supervision should provide a framework of support which enable them to achieve this.

### Entrustable Professional Activities of Supervision

The entrustable professional activities (EPAs) of supervision are those groups or clusters of activities which provide clinical oversight and learning support of students and trainees in the clinical environment.

They fall into six main categories:

*The Clinical Setting*

*Trainee learning*

*Professional development*

*Assessment*

*Manage trainee performance*

*Mindful practice*

These EPAs provide the framework which supports trainees as they travel on their professional journey. The framework links the key domains of patient safety and trainee learning.

The supervision framework is represented in a pictorial model (overleaf) and each EPA is discussed in greater depth in the following pages.

# The Training Bicycle

**Management of Trainee Performance**

1. Label the following forms of clinical oversight correctly (routine, backstage, direct patient care or responsive).

Monitoring' trainees' activities rather than taking active role in patient care……………………………

Initiated by supervisor, trainee or other staff if more intensive support is required……………………..

The checking of notes, results etc. The trainee may or may not be aware……………………………...

Management in response to an emergency or absence of trainee………………………………………

2. Which of the following may result from lack of effective feedback? (Select more than one).

- ☐ Good performance is not reinforced and poor performance remains uncorrected.
- ☐ Trainees guess at their level of competence based on how confident they feel.
- ☐ Trainees like their supervisor
- ☐ Trainees assume 'no comment' means all is well.
- ☐ Trainees feel valued.
- ☐ Trainees may rely on unreliable hearsay form others for feedback.

3. When you become aware that there may be an issue with trainee performance, it is helpful to follow a structured process. Label the following activities from 1-4 in the correct order.

- ☐ Establish an action plan.
- ☐ Meet with the trainee to discuss the issues.
- ☐ Review progress at an agreed time.
- ☐ Confidentially gather information about the trainees performance.

## Assessment

1. Assessment can be formative or summative.

- ☐ True
- ☐ False

2. According to **Miller's pyramid**, number the following in the correct order from 1-4.

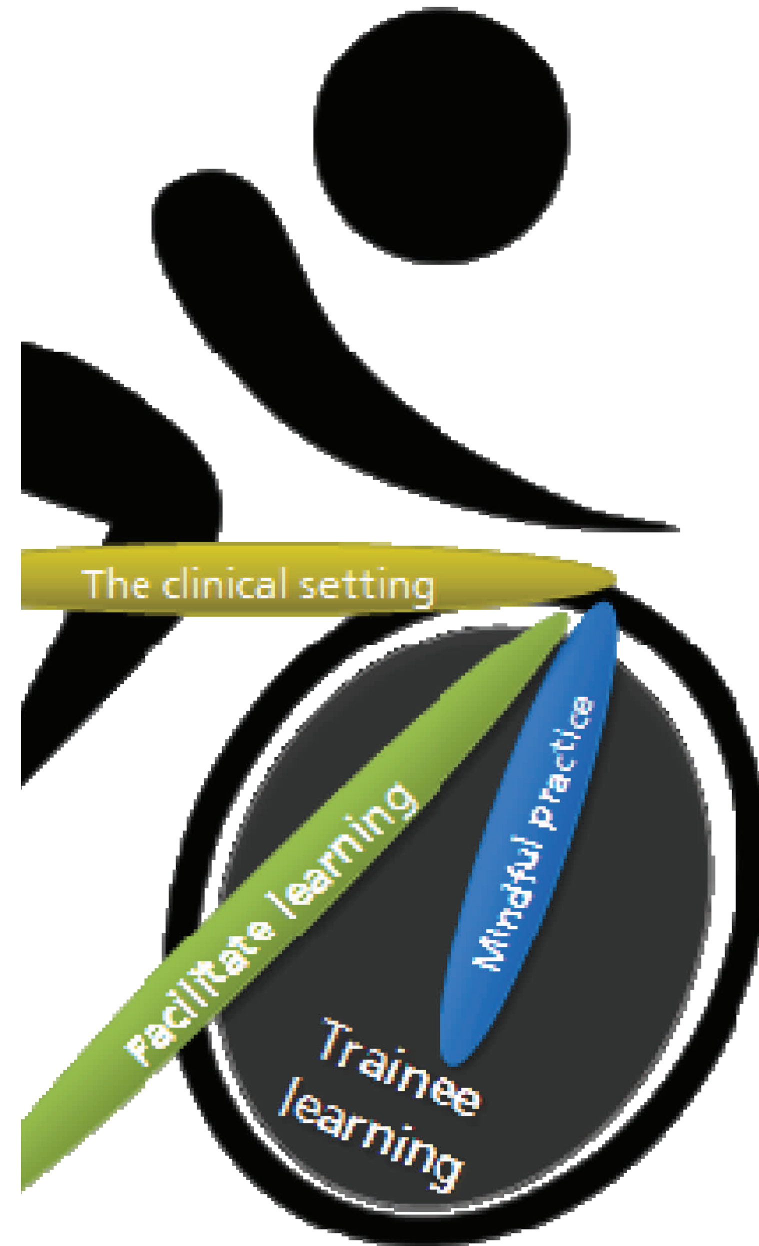
- ☐ Knows how
- ☐ Shows How
- ☐ Does
- ☐ Knows

3. Which two of the following methods do you feel would be most appropriate to assess the trainee's ability to perform a procedure?

- ☐ Multiple Choice Questions
- ☐ DOPs (directly observed procedure)
- ☐ Mini CEX
- ☐ Extended essay question

4. Which one of the following questions requires the trainee to demonstrate synthesis and analysis of knowledge?

- ☐ Name the four chambers of the heart.
- ☐ Outline the physiological functions which aid venous return
- ☐ Outline the diagnosis and management of peripheral vascular disease
- ☐ What do you think is going on with this patient and what should we do?



## *The Clinical Setting*

**Supervisory EPA:**

"Supervisors structure clinical work to enable learning to occur simultaneously with safe effective clinical practice."

**Learning Objective**: Maximise opportunities for learning in the clinical setting.

*Supervisors will:*

- *Ensure trainees are welcomed and valued as part of the clinical team*
- *Optimise learning opportunities for the varying levels of trainees within the clinical setting.*
- *Understand the importance of fostering a positive team culture and Interprofessional Education (IPE) in developing capacity for education and learning.*
- *Foster a culture of safety for learning in the absence of blame to ensure a culture of learning through safety and quality improvement*
- *Be inclusive of differing personal styles, cultural diversity and professions within the clinical setting.*
- *Demonstrate an awareness of key barriers to learning and wherever possible minimise such barriers.*
- *Advocate for appropriate staffing levels and infrastructure to facilitate clinical learning*
- *Ensures provision of adequate induction (orientation); balance service delivery with education*

Learning occurs within clinical settings which are dynamic and often frenetic(14). However such clinical settings are primarily places of patient care, with quality and safety outcomes for patients paramount. Supervisors recognise that patient care and therefore clinical education occurs in teams. Much clinical care is undertaken by trainees working under considerable pressure and at times near the edge of their competence or experience. Supervisors want to facilitate learning within this clinical environment to both ensure patients are kept safe and to develop the competence of their junior doctors. There are methods of clinical working that ensures junior doctors receive maximal learning within their clinical work. All supervisors should strive to structure clinical work such that learning occurs simultaneously with clinical work.

## Trainee Learning

1. Which of the following hold true for Adult Learners?

- ☐ Adult learners like to be involved in the setting of learning goals and development of a plan to meet their goals.
- ☐ They work well with rigid content and highly directive instruction
- ☐ Adult learners are intrinsically motivated.

2. Place the correct term (Activist, Theorist, Pragmatist or Reflector) to match the following statements:

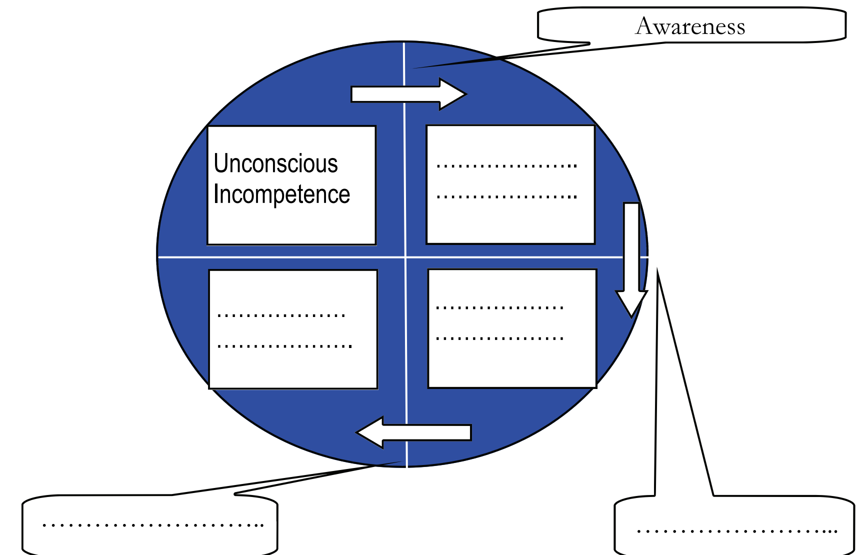
People who learn by doing are…………………………

Those who learn by observing and thinking about what happened are …………………………...

Those who want to put the learning into practice in the real world are…………………………...

Those who like to understand the theory behind the actions are……………………………

Complete the labeling the follow in g diagram of Peyton's stages in acquiring a skill:



**QUIZ**

**The Clinical Setting**

*Select the correct responses to the following questions/statements*

1. Which of the following should be included when orientating a trainee to a new unit?

- ☐ explicit detail of trainee duty requirements.
- ☐ let them know how you like your coffee
- ☐ information on learning opportunities with the unit, both clinically and in meetings.
- ☐ questioning of their knowledge within your interest area.
- ☐ an explanation of the importance of teaching moments in the work of the unit.
- ☐ encouragement to openly communicate and question.

2. In the provision of **teaching moments**, one should:

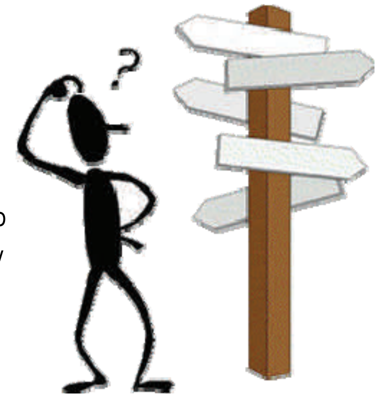
- ☐ prepare the trainees and set the scene by identification of instructive cases at the commencement of ward rounds or clinic.
- ☐ provide a mini lecture on your latest reading.
- ☐ provide a summary or wrap up to signal the end of the teaching and transition back to clinical work.

3. Teaching in the clinical setting:

- ☐ improves individual and team satisfaction.
- ☐ improves safety and quality of clinical care.
- ☐ generally interferes with clinical work.
- ☐ is disliked by patients and other clinical staff.
- ☐ supports a culture of openness and accountability.

4. What factors do you feel are impacting on your ability to teach in your current clinical setting?

***Welcome and orientate the trainee***



There are few things worse than arriving in an unfamiliar place where the people and processes are known to everyone except you, and where your roles and responsibilities are unclear. So too for the trainee; for most this occurs every 10-13 weeks when they change placements. uncertainty can lead to insecurity in the trainee and inefficiencies in practice when some work is done twice or worse still left undone if thought to be another person's responsibilities.

It makes good sense for trainees to be equipped with the information required to perform in their role at the beginning of the rotation. Expectations should be made explicit at the outset (eg: ways of documenting information, process for referrals and structure of discharge letters). While documented guidelines are important, even the most detailed and explicit document cannot replace the richness of a face to face conversation with a senior which aids in establishing rapport and may reduce perceived barriers to calling for assistance (3, 4) in dealing with clinical issues. It may also be the first opportunity the supervisor has with a trainee to get to know them and their perceived abilities and goals for future learning.

An induction process should outline such things as :

- Unit structure and team members including contact details
- Roles and responsibilities
- Case mix and suggested learning goals
- Hours of work and on-call commitments
- Guidelines for access to supervision both in hours and when on call.
- Learning opportunities including scheduled meeting such as radiology reviews etc
- The process for evaluation

### *Identifying and planning learning opportunities*

The clinical setting is full of opportunities for teaching and learning, but, being primarily places of services delivery, it is challenging to weave teaching and learning into this setting. What are trainees capable of and what do they wish or need to learn? Within the clinical setting, trainees learn by participating in workplace practices and cultures. Trainees at any level wish to be part of the team and feel useful. So....make use of their skills and aid them to develop further.

Awareness of the varying trainees' knowledge and abilities allows the adept supervisor to delegate certain tasks and responsibilities appropriately whilst maintaining oversight. "Junior doctors expect to gain supervisors' trust to act independently. Their confidence grows when supervisory access and guidance are flexible and readily available.
Allow trainees to take gradually increasing responsibility in the clinical setting, knowing that support is available as and if required; create what adult educators term 'a zone of safe learning(15)

### *Learning in Teams*

Learning in the clinical setting takes place in a 'community of practice' (15) where everyone in the team takes responsibility for engaging in and supporting learning. While more senior members of the team may set the 'tone' for learning in the clinical setting, the trainee (and the supervisor) will learn from a variety of sources. Supervisors often model this learning by asking questions of others,.

***Consider: Who are the people within your team who contribute to the trainee's learning?***

### Mindfulness and promoting reflection

Practicing true mindfulness on a daily basis requires dedication and practice. However, practicing and modelling reflection, as part of mindful practice is a good first step.

Educational theorist *David* Kolb (33) stresses that while experience and participating in the workplace provide for situated learning, it is the reflection on the experience and not just 'doing something' that permits full learning to occur.

Questions such as:

"Was that the best way to ask that question?"

"Could I have phrased it differently?"

"Did that investigation provide us with the information required?"

"Is this management pathway in keeping with the patient's wishes?"

all require the trainee (and supervisor) to question their practice in the interests of continual improvement and learning.

### Mindfulness as a supervisor

Just as self evaluation and reflection is important as a clinician, it is important as a supervisor.

Is the clinical environment safe for learning to occur?

Are team dynamics healthy and productive?

Are trainees learning?

It is helpful to discuss issues with other colleagues for support and calibration of opinion.

*Thank you for reading the Framework of Professional Activities for Supervisors Handbook. You may complete the quiz on the following pages if you wish to submit for CPD points or accreditation.*

**Promoting mindfulness**

There is much that supervisors can do to promote mindfulness in themselves and the team. It is often learnt through clinical stories and by observing exemplary practitioners.

Epstein provides the following method:

Priming

Set the expectation for self-observation in preparation for an encounter. Preparation behaviours may include, pausing, taking a deep breath, ensuring phone on silent or revision of notes.

*Availability*

Being fully available to a current situation can take practice in a busy clinical setting. It includes not only active listening and observing physical and emotional signs in a patient, but being aware of your own responses to the situation.

*Reflective questioning*

Invite doubt and questioning in trainees. Encourage them to seek alternative answers. Not "guess what I am thinking", but "What do you think?" Develop a habit of self questioning.

*Active engagement*

Be physically & mentally present to observe trainees in practice and for them to observe you.

*Modelling*

'Think out loud' and encourage this in trainees. This helps to verbalise processes and makes thinking overt.

*Practicing attentiveness*

Attending more fully to each situation. Letting go of the last moment and of interest in the next. Listening deeply and being aware of subtleties missed if less attentive - body language facial expressions. Practice clearing the mind in preparation for encounter.

*Praxis*

Encourage the processes of being mindful. Request trainees to 'observe themselves in action' and consider the dynamic between themselves and the patient.

*Evaluation*

Requires practitioners to reflect on their performance and how each encounter impacted on them as well as how well they managed technical skills or applied knowledge.

## *Trainee Learning*

**Supervisory EPA:**

"Supervisors use adult learning principles and knowledge of the trainees' individual requirements to facilitate trainee learning."

**Learning Objective**: Support trainees to identify and address their own learning needs.

*Supervisors will:*

- *Demonstrate an understanding of basic elements of adult learning*
- *Consider trainees as individuals with unique learning needs.*
- *Provide authentic feedback to assist trainee understanding of their learning requirements.*
- *Facilitate learning to multiple learners situated in a diverse team.*
- *Assist trainees to formulate learning plans linked to their curriculum, taking into account the clinical context.*
- *Foster enquiry, facilitate learning and promote excellence in trainees.*
- *Be proficient in appropriate methods for clinical teaching*
- *Plan and structure teaching, including actively utilising clinical moments to facilitate trainee learning*

In order to facilitate learning by trainees and ensure they are an active participant, the supervisor is required to draw on an understanding of adult learning principles as well as knowledge about the individual trainee. Knowledge of the trainee's current abilities and ongoing learning needs may come from the supervisor's personal observations and assessments, reports from other people or the trainee themselves. It is important that any learning opportunities are congruent with the current performance level of the trainee, build upon current knowledge and understanding, and foster an appetite for and engagement in additional learning opportunities.

**Adult learning theory (Knowles, Piaget, Schön)**

Adult learners generally have a well developed sense of self and as such are able to identify their learning needs and accept responsibility for doing so. They prefer their learning to be related to their current experience that will enable them to value add from the encounter. All adult learners come with their own previous life experience, knowledge and skills which can add much to the learning encounter.

Features of Adult Learners include:

- They are intrinsically motivated and benefit from being involved in the identification and establishment of learning goals
- A safe and comfortable learning climate encourages learners to interact and enhance their learning.
- Adult learners contribute to the mutual development of a learning plan
- Adult learners assist in identifying resources and methods to assist in the achievement of their learning goals.
- They may require support in the development and achievement of their learning objectives.
- Adult learners are well positioned to evaluate the progress of their learning and should be involved in the process.

In the role of clinical supervisor, it is important to consider these principals when supporting trainees in the workplace.

**Teaching & learning styles (Honey & Mumford, Kolb)**

Just as individuals come with their own innate personalities, they also have an individual preference for a learning style. Learning style indicators were developed by Peter Honey and Alan Mumford (2), based upon the work of Kolb (3), and they identified four distinct learning styles or preferences:

*Activists* are those people who learn by doing. Activists need to get their hands dirty, to dive in with both feet first. Have an open-minded approach to learning, involving themselves fully and without bias in new experiences.

*Reflectors* learn by observing and thinking about what happened. Prefer to stand back and view experiences from a number of different perspectives, collecting data and taking the time to work towards an appropriate conclusion .

*Pragmatists* need to be able to see how to put the learning into practice in the real world. Abstract concepts and games are of limited use unless they can see a way to put the ideas into action in their lives..

*Theorists* like to understand the theory behind the actions. They need models, concepts and facts in order to engage in the learning process. Prefer to analyse and synthesise, drawing new information into a system-

## Mindfulness in medicine

The principles of mindfulness can be helpful in current day medical practice.

In any encounter, whether with patient or trainee, it is very easy to be distracted by what has immediately preceded the interaction or feel 'pulled' by what is yet to be done. It takes determination and practice to set other thoughts aside to be fully available to the current situation.

Taking time to be mindful of 'self', the impact we have on our patients and trainees and to be thoughtful as to how we can improve our performance, makes for a great clinician and a great supervisor. Such reflective skills can be taught and developed in all. Mindfulness permits insight, presence and reflection. It invites deeper examination of the process of care as it requires an approach to tasks of critical curiosity.

Recent studies have reported decreased stress levels, increased job satisfaction and reduction in error in medical practitioners and students who have participated in mindfulness training.

**Factors for mindfulness**

Ronald Epstein; JAMA 1999 (30), lists four essential factors required for mindful practice.

*Attentive observation*

Being fully aware of each situation; the patient, the problem and oneself including responses. Look for the unexpected as well as the familiar.

Requires pre-attentive processing which allows formation of initial reac-

*Critical curiosity*

Attempt to see things as they are, not as you wish or think they should be. Invite doubt and question preconceived ideas. This can be challenging as it requires bias to be acknowledged but not necessarily dismissed.

*A beginners mind*

Approach a situation with fresh thoughts and be open to possibilities.

Be aware of habits and preconceived ideas.

*"A cultivated naïveté."*

*Presence*

Providing undistracted attention without the thoughts regarding the last patient or concerns for future waiting patients. It is often visible in a demeanour, a look or unhurried attitude which immediately conveys respect and attentiveness to patients or staff.

## *Mindful practice*

**Supervisory EPA:**

"Supervisors will be mindful in their role as clinical supervisor."

**Learning Objective:** Critically consider 'self' in performance as an educational leader, supervisor and clinician.

*Supervisors will:*

- *Exhibit an awareness of 'self' in the roles of educational leader, clinician and supervisor*
- *Seek to constantly evaluate self performance as an educational leader, supervisor and clinician*
- *Critically respond to self-assessment through on-going performance enhancement*
- *Seek and be receptive to feedback from others*

It is important to take time to be mindful of 'self', the impact we have on our patients and our students/trainees, and to be thoughtful as to how we can improve our performance. This makes for a great clinician and a great supervisor. Such reflective skills can be taught and developed in all.

Supervisors should seek to constantly evaluate their performance as a supervisor and clinician and critically respond to self-assessment and the feedback of others through on-going performance improvement.

Originally a concept of Buddhism, Mindfulness is the practice of being fully present and aware of and in any given moment. i.e. being Fully awake.

"Mindfulness can be thought of as a moment-to-moment, non-judgemental awareness, cultivated by paying attention in a specific way, that is, in the present moment, and as non-reactively, as non-judgementally, as openheartedly as possible."

(Kabat-Zinn)

### Situated Learning and the Hidden Curriculum

Trainee clinical learning is not an activity which occurs in isolation of the environment but whilst embedded and participating in it. The trainee *situated* in the clinical setting, is able to place much of their acquired knowledge into context and build on it further. Through engagement in shared activities and practices in the workspace, learning occurs; i.e. *situated learning.* This is the essence of the apprenticeship model of learning so familiar in medicine; trainees learn to become 'part of the team' and as such learn the relevance of their knowledge as well as many aspects of the 'hidden' curriculum.
The 'hidden' curriculum includes the socio-cultural norms of the profession; ways of working and communicating, cultural styles of medicine. It is through legitimate peripheral participation that trainees develop a sense of belonging.

### Assess educational needs

In order to ensure that the clinical experience and teaching a trainee is exposed to are at the appropriate level, and to 'scaffold' or build on current knowledge and skills, it is essential for the trainee and supervisor to have an understanding of the trainee's current abilities.

A variety of methods may be employed in determining learning needs. Initially, engaging in open and trusting dialogue with the trainee will assist them to reflect on their abilities and self identify both strengths and areas in need of further development. Observation of trainee work, their interaction with patients and reporting of history and examination findings will provide insight into their practice. In particular, synthesis of findings and formulation of management proposals will highlight their cognitive processes.

### Set learning objectives

The setting of clear goals with trainees helps clarify expectations between trainee and supervisor as well as paving a plan of progression for their professional learning. The supervisor's guidance will be important in highlighting the specific unique opportunities and requirements of the clinical attachment. The supervisor will also be instrumental in outlining the expectations of trainee performance at any given level of their training. This 'calibrating' of trainee and supervisor goals is best facilitated through a coordinated orientation process at the commencement of the rotation .
Trainees should be encouraged to set SMART goals. That is goals that are:

| | |
|---|---|
| ***S**pecific* | for example, related to increasing an area of understanding or skill. |
| ***M**easurable* | how will they know if their abilities have increased? Do they have a benchmark? |
| ***A**chievable* | is the goal within their grasp? |
| ***R**ealistic* | Is the opportunity to achieve the goal available in that clinical setting? |
| ***T**imely* | Is the timeframe for achieving the goal appropriate? Does it need revising? |

### Teaching a clinical skill

A skill is generally accepted to be usually something that can be broken into discrete steps, is not innate but learned, requires practice and usually has a specific desired outcome. Many of the clinical skills performed in medicine are complex in nature and carry a degree of risk. For the uninitiated, many of what are considered 'routine' skills by a practiced clinician will appear daunting. When one is extremely familiar with a skill ie 'unconsciously competent, it can be challenging to deconstruct the skill into components which need to be individually mastered.

Walker and Peyton (16) proposed a four step approach to teaching a skill;

*Demonstration* – the trainer provides a silent demonstration of the skill at real time

*Deconstruction* – the trainer describes the steps as s/he repeats the demonstration; often more slowly.

*Comprehension* – the trainer performs the skill again in response to the verbal description of the trainee.

*Performance* - the learner demonstrates the skill whilst at the same time describing the steps .

This process provides for repetitive focussed practice whilst at the same time separating the thinking from the 'doing'.

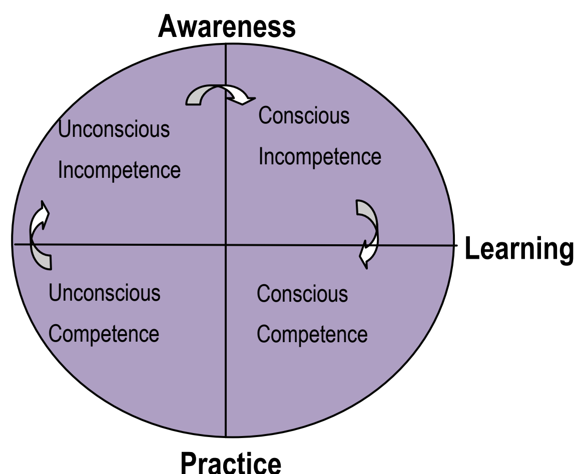



*Fig 1: Stages in Acquiring Skills. Adapted from Peyton (17)*

### Challenging Events

Many trainees encounter clinical events that are highly challenging to them personally and professionally. There is evidence that working through such episodes with a trusted supervisor is helpful in scaffolding the development of trainees through such episodes.

External factors and life events impact us all. For trainees such factors may impact their professional activities and learning. Supervisors alert to such external factors may be able to assist trainees to navigate through such pressures, facilitating on-going professional and personal development.

An open communication style and non-threatening enquiry will aid in developing insight into how the trainee is coping on the rotation.

### Getting back on track

Just as the causes for trainee stress or under-performance vary widely, so do the pathways for restitution.

Following the majority of challenging events, guided debriefing which includes 'unpacking' of the event and examination of contributing factors, along with an open and frank discussion of the effect on people involved, is the first step in moving forward.

Module 4 on Managing Trainee Performance identifies a number of agencies which can assist in support of an under-performing trainee. For most trainees, however, a challenging event may result in a crisis of confidence which is best addressed with support and encouragement from an interested supervisor.

Establishing with the uncertain trainee the availability of more senior colleagues should they feel the need at any time permits them to continue working knowing there is 'safety net' of support.

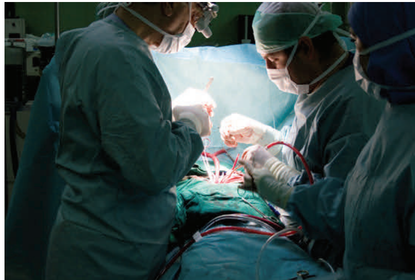
Additionally, follow up conversations to explore how the trainee is managing, provide an opportunity to increase or reduce support.

## Mentoring

Mentoring refers to the guidance and counsel provided by a more senior colleague(28) often in relation to professional development and career progression.
It may be formal or informal, often develops over time and may or may not have a relationship to the current clinical placement of the trainee. The essence of mentoring is that it is a private and confidential process between two people.

## Coaching

Is a process that provides support and encouragement to aid the trainee in meeting their potential . It may relate solely to an individual skill or area of practice or may extend to cover an area or professional development such as conflict management skills.



Many trainees are tentative about their abilities and most under-rate themselves. An insightful coach not only sees the trainee's abilities but through encouragement and support in performance of skills, permits the trainee to see them for themselves.

## Career Guidance

Many trainees seek to learn from the experience and guidance of more senior professionals in the field, initially when choosing a college training program to enter and later when considering specialty training and area of practice (i.e. community, tertiary, rural). Considerations such as scope of practice, availability of research and lifestyle impact all play a part in decision making.

Being prepared to have a discussion with trainees about what their aspirations are and if they need assistance or guidance help build a collegiate relationship and help them gain the information required or build the links they need to progress professionally.

## Small group teaching – structuring a teaching session

Small group teaching in the clinical environment is highly valued by learners because of its relevance. However, it is mostly opportunistic and time limited and for these reasons it is often considered to be unplanned. With some consideration, even the shortest if learning interactions can be planned and therefore increasingly meaningful for both the learner and clinical supervisor.

Choosing the 'right moment' to teach is important. Consider the following:

- Are there pressing urgent clinical issues which need attention?
- Is it late; is everyone tired and hungry?
- Do the learners feel safe and included?
- Does the teaching opportunity respect and include the patient?

Any teaching, regardless of time or setting, benefits from planning. Consider using the following framework:

**Set** – This includes what you need to consider before you start (level of learner, environment, patient etc). It also includes establishing the goal of the session and length. This may be as simple as the statement, "I would like to take 5 minutes to explore the process for reviewing a chest X-ray".

**Dialogue** – This is where the discussion/teaching occurs. This may be via questioning and probing and clarifying information as required as this allows gauging of the learners level of understanding. Questioning and discussion is useful to check for understanding.

**Closure** – Provides the 'wrap up' to end the session in providing a summary of what was covered. It may also be an opportune time to provide links for self directed learning or to contextual-

## *Assessment*

**Supervisory EPA:**

"Supervisors employ assessment in measuring trainee performance."

**Learning Objective**: Assess a trainee's performance through appropriate assessment and appraisal processes.

*Supervisors will:*

- *Be able to define the terms 'assessment', 'feedback' and 'evaluation'*
- *Demonstrate awareness of the range of functions served by assessment and appraisal processes.*
- *Be aware of the need to include a trainee's self-assessment as part of the assessment process.*
- *Demonstrate an understanding of the variety of assessment and appraisal methods available and their appropriate application*
- *Be aware of the strengths and limitations of key assessment instruments*
- *Be able to explain to trainees the assessment purpose*

**Definitions**

<u>*Assessment*</u>

Assessment can be *formative* or *summative*.
Formative assessment (often called appraisal) represents the 'How am I doing?' question. It is a way of judging a learner on their performance perhaps in relation to set criteria or perhaps as a global judgement.
Summative assessment represents the 'How did I do?' Again it can be based on how someone's performance or achievements meets defined criteria(11,12). The standards may be set by an external body such as a specialty college and a trainee's result may affect the career progression of the trainee.

The distinction between summative and formative can be considered in terms of the consequences. Formative assessment provides get feedback on areas for improvement and ideally a plan for improvement. In contrast, a summative assessment can have consequences such as having to repeat a clinical attachment or having to undertake specific remediation.

## *Professional Development*

**Supervisory EPA:**

"Supervisors support trainees in their personal and professional development."

**Learning Objective:** Display a willingness and ability to build a trusting professional relationship with trainees.

*Supervisors will:*

- *Know how to interact with trainees to promote their dignity, value and worth.*
- *Value opportunities to facilitate professional development of trainees*
- *Have the skills to enable trainees to discuss difficult and challenging clinical episodes and through these develop personally and professionally*
- *Enhance professional development of trainees by encouraging and promoting discussion on a range of professional issues including professional behaviours, ethics and career guidance.*
- *Demonstrate an understanding on the variety of pressures on trainees and provide 'pastoral care' in consideration of their wellbeing.*

**Professionalisation**

Transition from student to professional doctor is complex. There is no 'curriculum' for such a process. Much is intuited through observation. This transition can be assisted by supervisors with a caring responsive approach to the overall professional needs and development of trainees.

Senior clinicians, through role modelling and active engagement, are an important influencing factor on how trainees develop professionally and on their choice of career. This may occur via a variety of interactions, whether direct and formal supervision, coaching in skills development or a more long term mentoring relationship.

**The Hidden Curriculum**

Medical students and graduates embed the learnings gleaned in the educational sector into their practice during their time in the workplace. It is widely reported that whilst doing this, they are all too often confronted with the 'real' world or values that are unconsciously or half-consciously passed on from the faculty and older trainees which may conflict with what they have learnt. This is referred to as "the hidden curriculum."

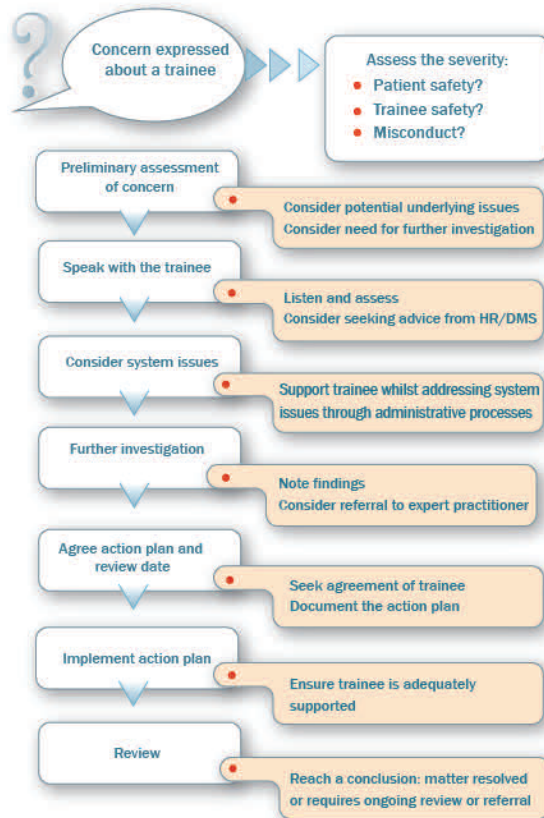
In transitioning to the clinical environment, many feel that they need to compromise some of the best practice or ethical standards learnt in the educational setting.

The supervisor has an important role in modelling desirable behaviours and attitudes they wish trainees to embrace. The alternative is that it will be a case of "Don't do as I do, do as I tell you."

## The process for managing underperformance

The flowchart (below) provides an outline of the process required in managing and supporting an under-performing trainee in an attempt to be objective, clear and fair.

### Trainee in difficulty: management outline




*Taken from Trainee in difficulty. A handbook for Directors of Clinical Training. Adelaide: SA MET 2010*

### Resources for support

Within most organisations, there are a number of skilled professionals who may be called on for advice and support. These include:

- Human resources
- Employee assistance program
- Education & Training committee
- Medical administration
- Director of training program
- Medical Board

Most problems with trainees are resolved by discussion and construction of a plan for improvement. Failure to acknowledge undepperformance may unfortunately have the effect of permitting the trainee to believe that their current level of performance is adequate and acceptable.

<u>Evaluation</u>

Is a process which allows the trainee to express their opinion of the trainer or the program(11). Ideally, to ensure honest and open critique, the evaluation process should be anonymous and collated by a third party.

*<u>Feedback</u>*

Is the process of discussing the trainee's progress and abilities during their training. Feedback may be formal as part of a structured review process or informal and no more than one or two words at the end of a ward round. All trainees are hungry for feedback (13) . Feedback is useful in identifying a trainee's strengths as well as areas requiring further development. Feedback has been shown to have a high correlation in improving performance most particularly when it is focused on a specific task (10). Feedback also provides an opportunity for the trainee's self-assessment to be calibrated against that of the supervisor, it can provide suggestions of how to gain additional knowledge and skills and it can clearly outline expected standards or goals to be achieved.

### Purpose of Assessment

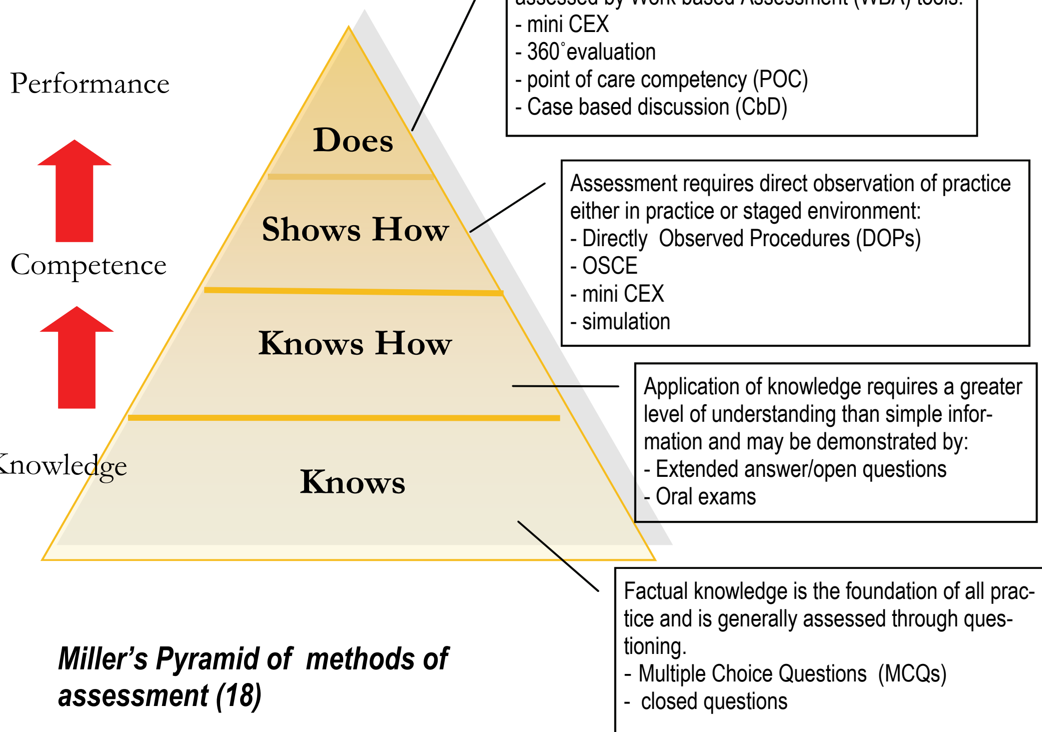
Assessment and appraisal involve making a judgement about someone's performance and fulfil a range of functions. Through observation of practice it allows the supervisor to review the current knowledge and abilities of the student or trainee in regard to specific activities and assists in determining future learning needs. It can also help to determine the degree of supervision required for the student/trainee; ie 'hands on' or 'hands off' and how safe or 'entrustable' they are in the clinical environment (9).

Assessment and appraisal also drive learning (10). The assessment activity in itself is a key learning opportunity for the student/trainee by providing observable performance with feedback of that performance.

The purpose for which the assessment or appraisal is to be used and the consequences of it are of importance, particularly to the trainee.(2) Is it to determine learning needs (assessment for learning) or is it to determine if the trainee's performance meets the required level and they can be deemed 'safe' in the workplace (assessment for certification)? The consequences of an assessment in this instance vary considerably. What is important is that the purpose of any assessment is discussed and made clear for both the trainee and the supervisor at the beginning of any interaction.(2)

Different methods of assessment consider different aspects of a student/trainee's performance and utilising a range of methods will help provide a more complete view of the student/trainee's abilities.

**Methods of Assessment**




***Miller's Pyramid of methods of assessment (18)***

*Point of Care Competency Assessment(9,19)*

"The decision to trust a trainee to manage a critically ill patient is based on much more than tests of competence. How can these judgments be incorporated into assessments?" is the question posed by Olle ten Cate in the BMJ 2006 (19). Performance in the workplace is more than a set of individual competencies or possession of knowledge. It is the willingness and ability to use their knowledge and skills in the execution of professional activity or practice; it is the 'real thing' (9).

Supervisors have known this for years. Most 'intuitively' know if a trainee can be *trusted* to manage certain clinical situations; that they either have the skills to deal with it personally or have the ability and willingness to appropriately call for assistance if needed. The question is how are these skills assessed?

*Feedback sandwich* - Many supervisors find it easier to provide corrective advice if it is wrapped more palatably with positive remarks. This involves placing the corrective comment between two positive aspects of feedback.

*Direct and uncensored* - There are the (hopefully) rare occasions when a significant event has occurred. The trainee should then receive direct, corrective feedback so as to avoid a reoccurrence. In such situations it is preferable to focus on the significant event alone.

***Consider:***

*How much feedback do you provide to the trainees you supervise?*

*How useful do you think your feedback is?*

**Elements of effective feedback (11)**

It has been documented that feedback is more effective if it has the following elements:

*Timely* - Provided as close as possible to any specified event.

*Specific* - Provides details of specific practice.

*Based on observed practice* - Trainees value knowing that the person providing feedback has actually observed them in action.

*Invites trainee input* - Allow the trainee opportunity to comment and provide their assessment.

*Constructive* - Provides a plan for ongoing professional development.

*In an appropriate setting* - Formal sessions should be in a private setting free from interruption. For routine informal feedback remember, praise publicly and criticize privately.

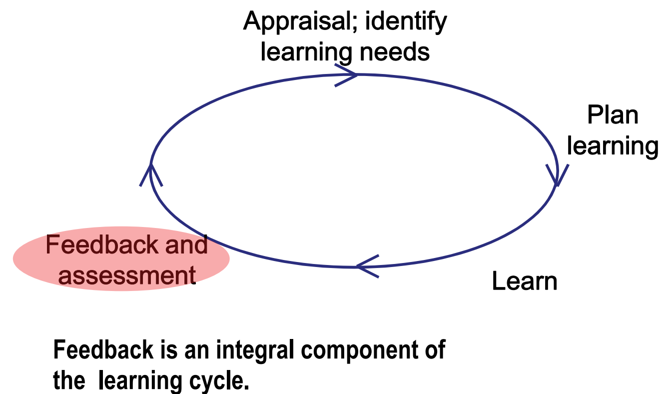
**Barriers to effective feedback**

Reasons cited as barriers to effective feedback include:

- Available time and lack of organisational structure. Sometimes it's the end of the rotation before the supervisor appreciates they have not provided feedback.
- Fear of upsetting the trainee and damaging their relationship.
- Fear of worsening the situation.
- Resistant or defensive trainee. A bad reaction to constructive feedback can result in the supervisor avoiding it in future.
- Worried about the lack of time and resources required for remediation (27).
- Inconsistent or absent reports of performance.

**Feedback**

The process of feedback can reinforce good practice as well as be corrective. It can encourage and motivate trainees and provide insight into the need to modify practice in order to improve.




**Feedback is an integral component of the learning cycle.**

**Different feedback models**

It is important that the method of feedback selected is appropriate to the type of feedback that is being conveyed. In all instances the language employed should be non-judgemental and based on observations of practice and/or behaviours.

*On the job informal feedback* - Everyday ongoing feedback should be specific and describe what the trainee did. For example; "you demonstrated a systematic approach to the respiratory exam."

*Pendleton model* - a structured 4 step approach which focuses on the positive aspects first, followed by areas for improvement. It actively involves the trainee.

1. The supervisor asks the trainee what is good about their performance.

2. The supervisor concurs with the agreed aspects of the trainee's appraisal and may elaborate on additional areas.

3. The supervisor asks the trainee if they have identified any areas for improvement. Given that the majority of trainees are quite harsh on themselves, this step can remove the onus from the supervisor to raise areas in need of improvement. Instead they validate in step 4.

4. The supervisor may agree with the trainee's assessment of their need to improve or may feel they need to moderate it or mention additional areas.

This method has a built in mechanism for reviewing the trainee's self assessment and offering moderation against the supervisors assessment.

*Mini CEX (20)*

The mini-clinical evaluation exercise or mini-CEX requires clinical supervisors to observe an aspect of the trainees practice and rate it against domains listed. The form provides a process to formalise the observations and judgements supervisors perform daily in their normal practice with trainees. The mini-CEX is intended to be brief, taking approximately 15 minutes for the observation with an additional 5 minutes to provide feedback on the encounter.

Not all domains will be observed in an individual interaction, and can be marked as such. However, repeated sampling over each year permits all domains to be covered. Evidence in the literature (20) suggests that the competent trainee is readily identified by 3-4 mini-CEX assessments but at least double the number of assessments are required to determine the ability of the borderline trainee.

*Case Based Discussion (CbD)*

Case based discussion, or chart simulated recall, is a powerful and valid (10) method for assessing clinical performance and provides the opportunity and structure to cover problem definition or diagnosis, clinical reasoning, management and anticipatory care (planning) (21). Though use of questioning, the supervisor is able to explore the trainee's clinical reasoning and understanding of the rationale involved in decision making. With the case notes available CbD also provides an opportunity to review entries made in the case notes and provide feedback on the quality of information available for others in the health care team. Case based discussion utilises many of the same questioning techniques employed in determining EPAs but differs in that it is often more formalised and focussed on an individual patient.

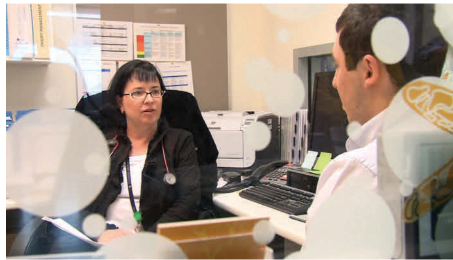
*Directly Observed Procedural Skills (DOPS)*

Observation and feedback on procedural skills is an integral aspect of surgical training (22) in particular but is also an essential component of all medical training (10, 23). It is an important part of trainee development for them to be observed and guided on ways to improve technique in order to gain in confidence and skill. DOPS provides an opportunity to ensure trainees' are performing procedures correctly, within prescribed guidelines and using checklists appropriately (24). It adds an important dimension to trainee logbook data which is a mandatory component of many training programs.

*360˚ review / multisource feedback including self assessment(24)*

It is not possible for one person in the workplace to observe a trainee in all situations or be privy to their interactions with others. It makes sense to collect opinion from a range of other health professionals as in the UK Foundation Program mini Peer Assessment Tool PAT (21)

## *Manage Trainee Performance*



**Supervisory EPA:**

"Supervisors will take responsibility for management of trainee performance."

***Learning Objective:*** Demonstrate leadership in the management of trainee performance, including promotion of excellence.

*Supervisors will:*

- *Ensure the trainee works within safe boundaries as determined by the assessment and appraisal process.*
- *Ensure the wellbeing and safety of patients is paramount at all times*
- *Evaluate the trainee's ability to self-assess and practice within scope.*
- *Commit to a feedback process that is authentic and learner centred and through mutual discussion assists continual improvement of performance.*
- *Ensure that required documentation is completed and forwarded to the appropriate body (ie: college, health service)*
- *Demonstrate an understanding of the processes required and supports available to manage an underperforming trainee or trainee in difficulty.*

**General Principles**

Management of trainee performance is important for patient safety and quality care, in addition to supporting learning and professional development of the trainee (4).

Assessment of their competence is a pre-requisite to provision of feedback designed to consolidate strengths and improve weaknesses.

Awareness of the trainee's level of insight into the standard of their performance will enable feedback that is understood by the trainee and hence enable them to improve.

Some trainees may need to be encouraged to embrace the feedback process and become actively involved in order to seek out specifics for improvement.

Should trainee insight be deficient, or responsiveness to feedback on performance sub-optimal, then supervisors need to be able to begin a process to remediate under-performance and monitor improvements.

If such improvements are sub-optimal, supervisors need to be able to activate a path of notification of poor performance through the appropriate pathway including drawing on specific expertise as required.

**Balancing safety and training**

"Clinical supervision must have patient safety and the quality of patient care as its primary purpose......The processes that ensure patient safety are essentially educational and form the backbone of the trainee's clinical learning" p 3(7).

"Clinical oversight" to refer to participation in patient care activities by clinical supervisors for the purpose of ensuring quality care. These activities can be divided into four categories (4):

*Routine oversight:* 'monitoring' trainees' activities rather than taking active role in patient care.

*Backstage oversight:* The checking of notes, results etc. The trainee may or may not be aware.

*Responsive oversight:* Initiated by supervisor, trainee or other staff if more intensive support is required.

*Direct patient care:* in response to emergency or absence of trainee.

**Purpose of management of trainee performance**

*Promoting excellence.* - it is important not to lose focus of trainees who are performing at an acceptable or advanced level and who would, with appropriate feedback and management to truly excel. A culture of striving for excellence can be contagious and generally stems 'from the top'.

*Identification of the trainee in difficulty* - Identifying the trainee in difficulty can be problematic as the 'culture' of medicine does not encourage disclosure and help-seeking behaviours. A supervisor who habitually provides effective oversight, will more readily identify signs that a trainee may be in difficulty. Pace (25) outlines some recognisable 'early warning signs':

- the doctor who is often difficult to find *(the disappearing act).*
- the doctor who works long hours but achieves less than other colleagues *(low work rate).*
- the doctor who is quick to lose their temper *(ward rage).*
- the doctor who is inflexible and has difficulty prioritising *(rigidity).*

*Encourage self-assessment of trainee.* - The ability to accurately self assess is one of the most important factors in ensuring safe effective care . The reality of medical practice is that the more senior one becomes the less likely one is to seek and receive feedback about clinical performance. Therefore, as part of management of performance it is important to assist the trainee to calibrate their self-assessment against the assessment of others

*Provision of constructive feedback* - Feedback is the cornerstone of effective clinical supervision and management of performance. It closes the loop between assessment of current knowledge and abilities and the establishment of future learning goals (26).

*Provision of remediation* - With any identification of sub-optimal performance, there is an obligation to assist the trainee with the development of a performance improvement plan.