Guideline Name	Supervision of Junior Doctors
Consultation and Date Approved	Accreditation subcommittee: 16 April 2012 and PMCV Board: 26 April 2012 Revised: February 2015 - Accreditation subcommittee: 16 March 2015 and PMCV Board: April 2015. Revised Accreditation subcommittee: 15 June 2015.
Responsible Officer	Accreditation Manager

Related documents

- *PMCV Accreditation Guide*
- *Accreditation of Intern Terms Guidelines*

Purpose & Scope [1] [2]

The purpose of these guidelines is to ensure that facilities are aware of the accreditation requirements for supervision of junior doctors to ensure the provision of safe patient care and quality clinical practice.

These guidelines apply to all Victorian facilities which provide prevocational medical training programs for interns and PGY2s.

The guidelines outline the:

- Clinical supervision requirements for interns and PGY2s.
- Responsibilities of supervisors in regards to clinical supervision of junior doctors.
- Requirements to be met in regards to clinical supervisors including identification, credentials, level of interaction with junior doctors and performance assessment.

Context

Prevocational medical training for junior doctors essentially comprises clinical learning in a supervised setting. Clinical supervision involves oversight by a clinical supervisor of clinical activities undertaken by junior doctors with the objective of developing their clinical skills and knowledge as they progress through their training towards independent practice.

Assessment of the supervision provided to junior doctors is a key component of accreditation.

For interns, these guidelines should be read in conjunction with the *PMCV Accreditation of Intern Terms Guidelines*.

Definitions

Facility: The organisation or clinical setting where junior doctors work. These organisations will usually be hospitals or health services but may also be health care centres or supervised practice in community settings (e.g. general practice) which have met PMCV accreditation requirements for prevocational medical training.

Term: The specific rotation undertaken by the junior doctor. Each term involves a clinical team, service or unit attachment where the junior doctor works and where clinical training takes place. All terms must be accredited.

Junior Doctor: A medical practitioner who is their first two years of prevocational medical training (intern or PGY2). Also referred to as junior medical officers (JMOs) or hospital medical officers (HMOs).

Intern: Junior doctors who are in their first year of prevocational medical training.

---

[1] These guidelines replaced the Supervision POLICY for Health Services/General Practices for Prevocational Doctors in Victoria approved in April 2012 and the Supervision GUIDELINE for Health Services/General Practices for Prevocational Doctors in Victoria approved in August 2012 (repealed by the PMCV Board in February 2015).

[2] Ensure definitions align with other PMCV policy and guideline documents.

Director of Medical Services: The senior administrative medical administrator who leads the medical workforce at a facility.

Supervisor of Intern Training (SIT): A medical practitioner who oversees the training and education provided to interns in the intern training program provided by a facility.

Director of Clinical Training (DCT): A medical practitioner with responsibility for implementing the intern training program or the training and education provided to PGY2 doctors at a facility (intern and/or PGY2) program.

Term Supervisor: A medical practitioner designated to be responsible for the coordination of clinical training of interns and PGY2s rotating to that unit including orientation, monitoring and assessment.

Clinical Supervisor: A clinical supervisor is an appropriately qualified and recognised professional who guides prevocational trainees' education and training during clinical placements, is responsible for ensuring safe, appropriate and high-quality patient care and whose role may encompass educational, support and managerial functions. The clinical supervisor may be a member of senior medical staff and/or a more senior doctor-in-training (registrar, more senior HMO).

Clinical Supervision: This involves the direct or indirect oversight by a clinical supervisor of professional procedures and/or processes performed by a junior doctor within a clinical placement (or term) for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each trainee's experience of providing safe, appropriate and high-quality patient care[3], [4]

- Direct supervision means that the clinical supervisor is present, observes, works with and directs the junior doctor who is being supervised i.e. The clinical supervisor is physically present at the workplace, within or covering the same unit as the prevocational trainee.
- Indirect supervision means that the clinical supervisor is not physically present to directly observe activities undertaken by the junior doctor but is easily contactable (e.g. by telephone).

[3] National Clinical Supervision Support Framework, Health Workforce Australia, 2011 (adapted to prevocational trainees)

[4] S. Kilminster, D. Cottrell, J. Grant & B. Jolly 2007, 'AMEE Guide No. 27: Effective educational and clinical supervision', Medical Teacher, 29(1): 2–19.

Guideline Details

Responsibilities of medical staff

Senior Clinical Management
Senior clinical managers, such as the Director of Medical Services, Directors of Training and Term Supervisors, are ultimately responsible for ensuring that all junior doctors are appropriately supervised according to the following standards:

- Interns/PGY2s are supervised at all times at a level appropriate to their experience and responsibilities (*accreditation standard 8.1.1*).
- Supervision is provided by qualified medical staff with appropriate competencies, skills, knowledge, authority, time and resources to participate in training and/or orientation programs (*accreditation standard 8.1.2*).
- Intern/PGY2 supervisors understand their roles and responsibilities in assisting interns/PGY2s to meet learning objectives, and demonstrate a commitment to junior doctor training (*accreditation standard 8.1.3*).
- The intern/PGY2 training program regularly evaluates the adequacy and effectiveness of supervision of junior doctors (*accreditation standard 8.1.4*).
- Staff involved in intern/PGY2 training have access to professional development activities to support improvement in the quality of the junior doctor training program (*accreditation standard 8.1.5*).

Senior Medical Staff
When supervising junior doctors, senior medical staff should ensure that junior doctors within their unit have clinical supervision that at all times is sufficient to ensure good clinical care, and that provides a safe learning environment. They should also be aware of the clinical performance of the junior doctors in their unit via feedback from more senior doctors-in-training and via direct observation/interaction.

Senior Doctors-in-Training (registrars, senior HMOs)
Clinical supervision of junior doctors may also be undertaken by more senior doctors-in-training such as registrars and PGY3 and above medical officers, following assessment by senior supervisors in the unit that they have the necessary skills and experience to undertake such a role.

Junior Doctors
Prevocational doctors have a responsibility to provide clinical practice within their level of knowledge and experience.

Internship enables medical graduates to begin to take supervised responsibility for patient care and consolidate the skills that they have learnt at medical school. Interns must consult a clinical supervisor regarding management plans for all patients, and all patients should undergo review by a more senior doctor (at some point during presentation/admission) prior to discharge.

PGY2 doctors remain under clinical supervision (as do all junior doctors) but take on increasing responsibility for patient care. In particular they begin to make management decisions as part of their progress towards independent practice, particularly towards the end of each term, and towards the end of the PGY2 year as the PGY2 gains competence in the management of unit patients. As a general rule, PGY2s should consult their clinical supervisor regarding patient admissions, discharges, and significant changes in patient clinical condition or management.

Clinical supervisors

Interns and PGY2s are to be supervised by clinical supervisors appropriate to their level of knowledge and experience at all times.

Identification of Clinical Supervisors

A clinical supervisor should be identified for each patient for the junior doctor at all times. Suitable replacement supervisors should be identified if the nominated clinical supervisor is not available.

A senior medical staff member in each unit should be identified as the *Term Supervisor* for junior doctors. The Term Supervisor is responsible for the coordination of clinical training of junior doctors rotating to that unit including orientation, monitoring and assessment (see *PMCV Term Supervisor Position Description*).

For intern terms, Term Supervisors should have:

- Fellowship of the Royal Australian College of Physicians for mandatory medicine intern terms.
- Fellowship of the Royal Australian College of Surgeons for mandatory surgery intern terms.
- Fellowship of the Australian College of Emergency Medicine, or alternatively, Fellowship of RACGP or ACRRM for mandatory emergency medical care intern terms
- For other intern & PGY2 terms, Term Supervisors should have relevant Fellowships including of the RACGP.

Interaction with Clinical Supervisors

Regular interaction of junior doctors with clinical supervisors is vital and a clinical supervisor should be contactable at all times if required by the junior doctor.

Term Supervisors should interact at least weekly with the junior doctors for whom they have responsibility.

Senior medical staff (SMS) should regularly supervise their junior doctors, and opportunities for this should be made available in junior doctor rosters (e.g. ward rounds, outpatients, theatre, supervised handovers). The frequency of contact with SMS will depend on the clinical specialty but, as a minimum, junior doctors should have daily contact with SMS from emergency/critical care units, contact with SMS from medical/surgical units 2-3 times per week and weekly contact with SMS in sub-acute terms.

Performance of Clinical Supervisors

The performance of clinical supervisors should be regularly reviewed as a part of regular performance review of senior medical staff and more senior doctors-in-training and additional support/training provided if required. Clinical supervisors should receive feedback in relation to their clinical supervision.

Supervision requirements for interns

Mandatory terms

Interns should generally be directly supervised (either by a more senior doctor-in-training or by a member of the senior medical staff) for the duration of their shift. Should the immediate clinical supervisor be unavailable (e.g. in theatre/ afternoon off), an alternative supervisor with a similar level of experience should be nominated.

Other terms
The principles of supervision in other terms are similar to the principles of supervision in mandatory terms. In general, supervision should be direct, however in sub-acute units, supervision may include a combination of direct and indirect supervision. During any period of indirect supervision, the intern should have an escalation protocol that identifies more senior medical support if required in an emergency. This should be available within 10 minutes.

Supervision of interns in general practice terms should be undertaken using the *parallel consulting* model at all times (whereby the clinical supervisor reviews each patient with the intern). The immediate supervising clinician should primarily be a general practitioner (FRACGP) but may be a general practice registrar who has been assessed as being appropriately skilled to undertake clinical supervision.

Handover
Intern-to-intern handovers at times of shift change (e.g. night to morning, day to evening and evening to night shifts) should be supervised by a more senior doctor-in-training where possible.

After hours and cover shifts
The majority of rostered intern hours should be in normal operating (business) hours to ensure alignment with their unit clinical supervisors. In general, for mandatory medical and surgical terms, no more than 30% of rostered hours should be after hours and this should be with direct supervision. Other terms may include a greater proportion of after hours' including night terms, however should still provide direct supervision.

The principles that apply to clinical supervision within normal operating hours also apply after hours.

At no time should interns be the sole doctor in the hospital.

As for in-hours, during after hours' shifts, interns must consult a clinical supervisor about the management of all patients, and all patients should undergo review by a more senior doctor prior to discharge.

On-call & After Hours in General Practice
Interns may be expected to take calls direct from patients when on-call following patient triage by a Division 1 nurse or equivalent, however must discuss their assessment of the patient with their clinical supervisor. A clinical supervisor should be in attendance when seeing any patient on-call.

Supervision requirements for PGY2s

In-hours clinical supervision
Clinical supervision may be direct or indirect, depending on the unit patient acuity and complexity. Where supervision is predominantly indirect, the PGY2 trainee should have as a minimum daily contact with their clinical supervisor, including a daily ward round (may be less frequent for subacute).

In situations where rotation clinical supervision is predominantly indirect, the PGY2 must be sufficiently supported in the role via:

- Formal unit orientation at commencement
- Unit education at least weekly
- Orientation to unit-specific clinical guidelines, policies and protocols including escalation protocols
- Clinical emergency procedure training and other clinical procedure training
- Mid and end of term appraisals

These supports are also required for PGY2s who undertake a relieving roster in terms where the predominant supervision is indirect. Supervising staff should be aware that additional support is likely to be required to a relieving PGY2, and should ensure that this is provided.

After hours & cover shifts

It is recognised that PGY2s increasingly cover the after-hours and on-call rosters. It is recommended that higher-acuity units provide direct supervision to PGY2s after-hours.

Where PGY2s cover units after hours:

- The PGY2 should participate in handovers led by a more senior doctor-in-training at the commencement and completion of each cover shift.
- A clinical supervisor for the PGY2 should be identified either on-site or off-site, and should always be available immediately by telephone.
- The PGY2 should consult their clinical supervisor as a minimum regarding patient admissions, discharges and significant changes in patient clinical condition or management.
- After hours, clinical supervisors or a nominated delegate should be available to attend and support the PGY2 within 10 minutes if required.

General Practice terms

A PGY2 doctor is permitted to undertake an agreed range of independent consultations where the clinical supervisor is "on-call" for the prevocational doctor and will only review the management of a certain type or number of consultations. The immediate supervising clinician should primarily be a general practitioner (FRACGP) but may be a general practice registrar who has been assessed as being appropriately skilled to undertake clinical supervision.

PGY2s may be expected to take calls direct from patients when on-call following patient triage by a Division 1 nurse or equivalent, however must discuss their assessment of the patient with their clinical supervisor.

Clinical Handover

Supervision by senior medical staff supervisors of selected clinical handovers (e.g. night to morning handovers for large admitting/presenting units such as general medicine and emergency medicine) is recommended.

References

- SA Institute of Medical Education, *Supervision Policy for Interns in Accredited Facilities,* June 2010
- NSW Institute of Medical Education*, Clinical Supervision Policy,* November 2008
- Postgraduate Medical Council of Western Australia, *Policy – Supervision of Prevocational Doctors,* August 2008
- Postgraduate Medical Council of Queensland, *Supervision Policy for Interns in Accredited Facilities*, June 2008
- Medical Board of Australia, *Guideline: Supervised practice for limited registration*, June 2011(reviewed)
- Royal Australian College of General Practice, *Standards for the Supervision of Prevocational Doctors in General Practice,* November 2007
- Guidelines for Supervision of PGPPP Doctors, November 2008
- Kilminster S et al; *Effective educational and clinical supervision*, AMEE Guide No. 27, Medical Teacher 2007; vol. 29: pp 2-19
- Australian Medical Association, *Safe Handover: Safe Patients. Guidance on Clinical Handover for Clinicians and Managers,* 2006

- Orman SA, Thornton VJ, *Analysis of junior doctor supervision in Australian emergency departments;* Emergency Medicine Australasia (2010), : 22, 301-309
- Sir John Temple, *Time for Training: A Review of the Impact of the European Working Time Directive on the Quality of Training:* NHS, UK, 2010
- Royal Australasian College of Physicians, *Criteria for Accreditation of Basic Physician Training*
- Australasian College for Emergency Medicine, *Policy on the Supervision of Junior Medical Staff in the Emergency Department*, 2008.