Purpose and Scope

The purpose of these guidelines is to ensure that facilities and supervisors are aware of the clinical supervision requirements for junior doctors to promote the provision of safe patient care and junior doctor wellbeing. Assessment of the clinical supervision provided to junior doctors, in conjunction with the PMCV Clinical Learning for Junior Doctors Guidelines, is a key component of prevocational medical training accreditation.¹

These guidelines apply to all Victorian prevocational medical training facilities. Junior doctors are defined as medical graduates in their first two years of clinical practice, specifically interns and PGY2s.

Definitions

**Internship**² is a period of mandatory supervised general clinical experience (provisional registration). It allows medical graduates to consolidate and apply clinical knowledge and skills while taking increasing responsibility for the provision of safe, high quality patient care. Diagnostic skills, communication skills, management skills, including therapeutic and procedural skills, and professionalism are developed under appropriate supervision. Internship also informs career choices for many graduates by providing experience in different medical specialties including general practice, and providing a grounding for subsequent vocational (specialist) training. **Completion of the internship leads to general registration** where the doctor has been assessed as having the skills, knowledge and experience to work as a safe entry level medical practitioner. **As a general rule, interns must consult a clinical supervisor regarding management plans for all patients, and all patients should undergo a review by a clinical supervisor (at some point during presentation and/or admission) prior to discharge.** Internship comprises 47 weeks of supervised clinical experience including terms in core medicine, surgery and emergency care.

**PGY2 doctors** (2nd year junior doctors) remain under clinical supervision but take on increasing responsibility for patient care. 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 a general rule, PGY2s should consult their clinical supervisor regarding patient admissions, discharges, and significant changes in patient clinical condition or management.** Clinical learning provided should ensure the provision of appropriate prevocational medical training to support their professional development needs and enable transition to vocational training programs.

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¹ Particularly in relation to the accreditation standards listed
² MBA Intern Registration Standard
**Clinical supervisors** must ensure a safe environment for patients and junior doctors, ensure optimal clinical learning, allow for increasing opportunities for independent decision-making (as skills and knowledge progress and scope of practice changes) and be readily available. A **clinical supervisor** is an appropriately qualified, registered\(^3\) medical practitioner who has experience in managing patients in the relevant discipline and knowledge of the principles, process and skills of clinical supervision. Clinical supervisors may be senior medical staff or a more senior doctor-in-training (registrar, PGY3 and above) following assessment by the term supervisor in the unit that they have the necessary skills, capabilities and experience to undertake such a supervisory role.\(^4\) Clinical supervision may be **direct** where the supervisor is physically present, or **indirect** where the clinical supervisor is not physically present but is easily contactable and there are clear escalation protocols.

**Director of Clinical Training (DCT)**\(^5\) is a medical practitioner who oversees the education and training provided to junior doctors and usually reports to the Director of Medical Services. The DCT/SIT should have appropriate credentials; should have a position description which outlines responsibilities in relation to education and training; educational leadership; supervision and assessment; mentoring, counselling and advocacy; quality improvement and professional development (see Appendix A).

**Term Supervisor** is responsible for the coordination of clinical training of junior doctors including orientation, clinical learning, monitoring of overall supervision and support, performance assessment and feedback and evaluation. **Term Supervisors are required to have relevant medical Fellowships** (i.e. Fellowship of the Royal Australian College of Physicians for mandatory (core) medicine intern terms and Fellowship of the Royal Australian College of Surgeons for mandatory (core) surgery intern terms). In emergency terms, while it is preferable for the Term Supervisor to have Fellowship of the Australian College of Emergency Medicine, Fellowship with another College is acceptable with appropriate skills in emergency patient management.

**Other supervisors:**

- For specific clinical learning purposes, junior doctors may be supervised by other supervisors including nurse practitioners, educators, health workers e.g. in general practice or other community based settings.
- Supervision by other supervisors will be assessed by the PMCV Accreditation Committee to ensure that it is appropriate and that the designated supervisor is skilled and experienced in supervision and that the learning is appropriate.
- Such supervisors and work must be overseen by the Term Supervisor.

**Accreditation Standards**

**Supervision specific standards**

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

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3 With the Medical Board of Australia
4 International Medical Graduates (IMGs) may be considered clinical supervisors if they have been assessed by the relevant College as being substantially comparable to an Australian-trained Fellow and are undergoing a period of supervised practice of no longer than 12 months
5 The Supervisor of Intern Training (SIT) oversees the training and education provided to interns
Other relevant standards

<table>
<thead>
<tr>
<th>3.1.3</th>
<th>Interns/PGY2s participate in formal orientation programs and are supported and supervised where appropriate to provide safe and effective clinical handover between terms and shifts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>The facility provides for interns/PGY2s to attend formal education sessions, and ensures that they are supported by senior medical staff to do so.</td>
</tr>
<tr>
<td>5.2.1</td>
<td>The facility provides regular, formal and documented feedback to interns/PGY2s on their performance within each rotation.</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Interns/PGY2s receive timely and progressive informal feedback from clinical supervisors during every rotation.</td>
</tr>
<tr>
<td>5.2.5</td>
<td>The facility has clear procedures to address immediately any concerns about patient safety related to the performance of interns/PGY2s.</td>
</tr>
<tr>
<td>7.2.2</td>
<td>The duties, rostering, working hours and supervision of interns/PGY2s are consistent with the delivery of high-quality, safe patient care and with intern/PGY2 welfare.</td>
</tr>
</tbody>
</table>

Guideline Details

Assessment of the clinical supervision provided to junior doctors is a key component of prevocational medical training accreditation. The statements in the following sections highlight areas assessed.

Clinical Governance (overall training program)

The employer is ultimately responsible for ensuring that junior doctors are appropriately supervised to provide safe patient care and that all relevant accreditation standards are met.

1. The Supervisor of Intern Training, Director of Clinical Training and Term Supervisors are adequately resourced to undertake their responsibilities. All should have a specific position description.
2. The training program has clear procedures to address immediately any concerns about patient safety related to the performance of junior doctors.
3. The adequacy and effectiveness of supervision of junior doctors is evaluated.

For junior doctors:

4. Junior doctors are supervised at all times at a level appropriate to their experience.
5. The process for contacting clinical supervisors and escalating clinical concerns is clear at all times.
6. Teaching time is provided and protected.
7. The performance of all junior doctors is assessed and feedback, formal and informal, is provided.

For clinical supervisors:

8. Clinical supervisors are aware of their responsibilities in providing clinical supervision.
9. Clinical supervisors have the necessary skills and competencies to provide clinical supervision.
10. The workload of clinical supervisors is monitored to ensure they can effectively fulfill their role.
11. There is access to professional development for clinical supervisors to support improvement in the quality of junior doctor training.

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6 See Appendix A for role and responsibilities.
7 Clinical supervisors must constantly monitor the performance and wellbeing of junior doctors.
8 Refer to PMCV Performance Assessment and Feedback Guidelines for Junior Doctors.
9 Clinical supervisor skills include the capability to provide clinical advice to junior doctors, to monitor the performance of junior doctors, to provide feedback on their performance to junior doctors and to complete formal assessments.
10 The performance of clinical supervisors should be reviewed as a part of regular performance assessment process and additional support/training provided if required. Clinical supervisors should also receive feedback.
11 Training in supervisory skills (refer definition and footnote 18) should be available to senior clinicians and should be provided to more senior doctors in training to prepare for the role of clinical supervisor.
Informed Consent
1. Interns should not be expected to consent patients for procedures.
2. PGY2s should not obtain informed consent unless they have observed the procedure, understand the risks involved and are able to assess the patient’s capacity to make an informed decision.
3. Interns and PGY2s should not be responsible for NFR Orders or Advanced Care Directives.

Clinical Supervision (in each rotation/term)
The duties, rostering, working hours and supervision of interns/PGY2s must be consistent with the delivery of safe patient care and provide a safe learning environment.\(^\text{12}\)

1. There is a nominated Term Supervisor\(^\text{13}\) with the required skills and qualifications.
2. The Term Supervisor ensures that their contact with each junior doctor is sufficient to allow an effective assessment of the junior doctor’s performance at mid- and end-term and provide formal feedback in a meeting with the junior doctor.
3. There is a clinical supervisor with the appropriate capabilities and experience identified for each patient for the junior doctor at ALL times and that all junior doctors know who their immediate clinical supervisor is for every patient. For interns, a clinical supervisor must be awake and onsite at all times (i.e. direct supervision) for core terms but for non-core intern terms and for PGY2s clinical supervisors may be offsite but must be easily contactable and available onsite within 10 minutes (i.e. indirect supervision).
4. Clinical supervisors in the unit regularly monitor the performance and wellbeing of junior doctors and are aware of processes to support junior doctors in distress.
5. Junior doctors are rostered more time with consultant supervision than when there is less supervision (ideally no more than 30% of rostered time afterhours particularly in core intern terms\(^\text{14}\)).
   a. Junior doctors have interaction with the Term Supervisor/ senior medical staff in the unit at least once per week.\(^\text{15}\)
   b. Junior doctors have regular (daily for interns) contact with, and informal feedback from, an appropriate clinical supervisor (including registrars).
6. Junior doctors are adequately oriented\(^\text{16}\) and supervised to provide safe and effective handover.\(^\text{17}\)
7. Interns should not undertake these procedures without direct supervision: pleural taps, chest tube insertion, lumbar puncture, central line insertion, abdominal paracentesis, instrumental obstetric deliveries, joint aspiration, skin biopsy or biopsy of deep organs, suprapubic bladder puncture, intubation, pericardial aspiration or arterial line insertion.\(^\text{18}\)
8. For emergency terms:
   a. A clinical supervisor is available to supervise the junior doctor, at all times, who has the capacity for case-by-case supervision of technical skills, interpretation of tests and clinical decision-making to

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\(^{12}\) This includes whether: rostered hours reflect the time it takes to complete the work required safely and effectively, the hours being worked by junior doctors ensures their well-being and that of their patients; takes account of a junior doctor’s skills, knowledge, experience and competence AND that supervision is in accordance with the accreditation standards

\(^{13}\) Refer definition on page 2 and Appendix B. There should be a specific position description.

\(^{14}\) Emergency may be an exception to this given rotating roster and clinical supervisors in the department all the time, depending on the experience and skills of the supervisor.

\(^{15}\) To learn expert skills in managing patients in that discipline. Opportunities for this should be made available in junior doctor rosters (e.g. ward rounds, outpatients, theatre, supervised handovers).

\(^{16}\) Orientation should include direct interaction with senior clinical supervisor to discuss the medical expectations of the unit.

\(^{17}\) Intern-to-intern handovers at times of shift change should be supervised by a clinical supervisor where possible. For PGY2s, 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.

\(^{18}\) Northern Health policy
maximise patient safety and opportunities for clinical learning.\(^{19}\)

b. All patients seen by interns must be reviewed by a clinical supervisor\(^{20}\) prior to discharge.

c. For PGY2s supervision may be direct or indirect (although supervisor must be readily available) depending on the complexity and acuteness of the patient but should include case by case discussion.

d. At no time should interns be the sole doctor in the emergency department.

e. Interns must be aware of and familiar with agreed protocols for the management of common serious conditions in case they are required to initiate management of a potentially life-threatening condition.

f. Interns should not be expected to manage obstetric patients or children less than two years of age without direct supervision.

g. Ideally, interns and PGY2s should have clinical interaction and teaching with a FACEEM, a Senior Medical Officer with sufficient emergency management experience or registrars who are members of ACEM at least weekly.

**Supervision requirements for interns and PGY2s in specific terms**

**Psychiatry terms**

Interns and PGY2s, particularly those with no prior experience in psychiatry, should be supervised by an appropriate clinical supervisor (psychiatrist or registrar) at all times. Interns and PGY2s should not be the only doctor on the ward.

In particular, Interns/PGY2s should not perform ECT without senior clinical supervision and work related to Mental Health Tribunals are subject to the following principles (analogous to consent for surgical procedures):

1. Interns may be responsible for preparing the written reports. However, prior to submission, the report should always be read and signed off by a consultant (not merely a verbal endorsement).

2. Interns may not attend tribunal meetings on their own – i.e. must be accompanied by a consultant or registrar.

3. PGY2s can take increasing responsibility for Mental Health Tribunal reports and meetings provided there is appropriate training and supervision. PGY2s may attend tribunal meetings provided there is a supervisor (consultant/registrar) available (at least on call).

Note that these principles apply to accreditation decisions in relation to all psychiatry intern and PGY2 posts in Victoria. Further it would be appreciated if facilities could review their psychiatry terms for interns and PGY2s to ensure that these requirements are being met.

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\(^{19}\) Australian College of Emergency Medicine (ACEM) *Policy on the Supervision of Junior Medical Staff in the Emergency Department* and *Guidelines for the Role of Interns in the Emergency Department*

\(^{20}\) With appropriate experience in emergency medicine
General Practice terms\textsuperscript{21}

The immediate supervising clinician should primarily be a general practitioner (FRACGP/ FACRRM) but may be a general practice registrar who has been assessed as being appropriately skilled to undertake clinical supervision. Other supervisors may be nominated under specific circumstances e.g. diabetic educator at a diabetic clinic.

It is important that the junior doctor is able to participate in the breadth of clinical experience undertaken by the general practice, and this includes experiencing different contexts of care e.g. visits to aged care facilities, local hospital, home visits and after-hours clinics with the clinical (GP) supervisor. Orientation is essential for all junior doctors undertaking a general practice term. This orientation would usually involve introduction to the practice systems and staff and observation of practice activities.

The junior doctor will then progress through various stages of training as they develop increasing clinical independence in the general practice setting. Generally, interns would complete the observation and second stage of training (perhaps begin the third stage) while PGY2s would likely progress to the end of the third stage and perhaps begin the fourth stage of training. Transition to the third and fourth stages of training only occurs when the supervisor is confident that the junior doctor can identify the need for additional support and seek assistance appropriately. Appendix C provides an example of a supervisor learning plan.

The observation stage involves the supervisors observing the junior doctor, and having the junior doctor observe them in a range of patient consultations within the context of general practice and should incorporate expectations and opportunities to assess competence.

The second stage of training involves the junior doctor being able to practice elements of the consultation with regular feedback and support from their supervisor. Parallel (Wave) Consulting\textsuperscript{22} involves the supervisor and the junior doctor undertaking patient consultations consecutively with supervisor feedback (given at the conclusion of EACH patient consultation) being an essential component.

During the third stage of training, the junior doctor is able to practice with feedback following each independent unobserved consultation. Consultations are reviewed by the supervisor (e.g. by reviewing the medical records of patients) after decision-making has already occurred and should focus on the junior doctor’s patient management strategies. During stage four training, the junior doctor is permitted to undertake an agreed range of ‘independent’ consultations in an environment where the supervisor is ‘on call’ for the junior doctor.

It is expected that the junior doctor will receive at least one hour a week of formal education including formal teaching by the supervisor (multi-level learners or multidisciplinary) and assessment of the junior doctor’s clinical performance will include: formative feedback at mid-term, formative assessments to determine appropriate levels of supervision (to transition stages of training) and summative feedback (completion of the relevant assessment form) to be forwarded to the parent health service.

Refer Appendix D for training plan example.

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.

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.

\textsuperscript{21} Adapted from PGPPP (Practice) Guidelines for the supervision and training of doctors in the Prevocational General Practice Placements Program, November 2010

\textsuperscript{22} A video prepared by Southern GP Training shows the parallel consulting process and benefits for GPs and junior doctors: https://www.youtube.com/watch?v=DGefe6yqfv8
Appendix A

Description of SIT/DCT Role:
The following are activities that a DCT/SIT would be expected to lead or be involved in, in relation to prevocational doctors. The specific activities appropriate for a DCT/SIT at an individual health service will depend on the roles/activities of other members of the health service’s medical education team.

**Education & Training**
Support and promotion of education & clinical training opportunities for junior doctors. Activities may include:
- Development, co-ordination, participation in and evaluation of orientation and education programs
- Development of learning needs analyses and educational resource materials
- Participation in clinical teaching
- Participation as a member of an educational team (e.g. Medical Education Committee)

**Educational Leadership**
- Liaison with, support of and provision of feedback to Term Supervisors and relevant clinical supervisors
- Actively support Succession Planning
- Advocate at the Executive level for the needs of junior doctors

**Supervision & Assessment**
- Review of junior doctors where performance issues are identified
- Participation in support and remediation programs for doctors with special needs or performance issues
- Liaison with other sites/rotating health services regarding rotating junior doctors
- Participation in end-of-year intern ‘certificate of completion’

**Mentoring, Counselling & Advocacy**
- Regular interaction with junior doctors
- Monitoring, support and referral of welfare issues of prevocational doctors
- Participation in mentor programs, career advice and general counselling
- Act as a role model to promote professional responsibility and ethics among junior doctors

**Administrative/Quality Improvement Activities May include participation in:**
- Planning / revising prevocational term descriptions and other resources (e.g. ROVER)
- Participation in prevocational accreditation activities
- Participation in policy and guideline development for medical education / welfare
- Supporting junior doctor engagement in training activities and review of feedback/evaluation

**Professional Development Activities**
- Ensure familiarity with requirements for and contemporary issues in relation to the education and training of junior doctors
- Participate in relevant professional development activities on a regular basis (PMCV, College, University)
Appendix B

Description of Term Supervisor role:

Administrative responsibilities
Oversee unit prevocational doctor roster(s) ensuring appropriate supervision and working hours

Orientation
Supporting unit orientation, including meeting with new junior doctors and discussing training goals for the term and oversee the development/review of relevant unit orientation/education resources (Position Descriptions, Unit Handbooks etc)

Education
- Have an understanding of curriculum requirements for junior doctors within the rotation
- Support unit formal and informal learning opportunities for junior doctors
- Support junior doctor attendance at relevant facility education programs
- Support supervision and teaching by other unit medical staff

Supervision
- Ensure that contact with each junior doctor is sufficient to allow an effective assessment of the junior doctor’s performance
- Directly supervises and oversees the supervision of others (e.g. registrars) to unit prevocational doctors

Performance Assessment
- Provide regular informal feedback to junior doctors
- Complete mid and end of term junior doctor performance appraisal and assessment (in conjunction with other unit medical staff) and discuss with the junior doctor (formal meeting)
- Identify the poorly performing doctor/doctor in difficulty and refer/manage with support

Support & Evaluation
- Provide general advice and support to unit junior doctors
- Regularly review junior doctor’s feedback of their term experiences, and use feedback to improve term experiences for junior doctors
## Appendix D

**PGPPP doctor's name:** Dr John Average  
Supervisor's name and contact details (including an emergency after-hours number and alternative contact if on-call responsibilities are undertaken)

**Identified areas of expertise:**
- Past experience as a physiotherapist.
- Completed a term in paediatrics.
- Has undertaken a junior registrar position in accident and emergency.

**Identified areas that need improvement:**
- Has not yet undertaken a term in women's health or obstetrics.
- Has no experience in palliative or end-of-life care.
- Doesn't feel confident in acute cardiology.
- Chronic disease management.

<table>
<thead>
<tr>
<th>Low risk scenarios:</th>
<th>Strategies:</th>
<th>How to access support</th>
</tr>
</thead>
</table>
| Daily consultations where John feels confident of his management approach eg URTIs in children Most nursing home visits Acute sporting injuries and minor trauma | Stage 3 approach, reviewing each patient at the end of the session. Requesting assistance “on the spot” as needed | Phone supervisor  
Phone advanced registrar for low risk questions  
Notify supervisor by messaging  
Seek nursing support as needed  
Use Therapeutic Guidelines Consult Murtagh |

<table>
<thead>
<tr>
<th>Moderate risk scenarios:</th>
<th>Strategies:</th>
<th>How to access support</th>
</tr>
</thead>
</table>
| Where John feels unsure of his approach or in the following scenarios  
Chronic disease consultations, especially care planning  
Mental health consultations  
Children who require medication (eg otitis media, moderate croup)  
Antenatal care | Stage 2 approach, reviewing the patient before they leave the consulting room | Phone/message supervisor and ask him to review this patient |

<table>
<thead>
<tr>
<th>High risk scenarios:</th>
<th>Strategies:</th>
<th>How to access support</th>
</tr>
</thead>
</table>
| Where the patient is at high risk  
Any consultation where the diagnosis is unclear and the patient is unwell  
Any seriously ill child  
Any immunisation (prior to giving the vaccine)  
Any neonate  
Any patient who expresses suicidality  
Any patient where you feel unsafe or worried | Stage 1 approach, reviewing the patient together | Phone/message supervisor and ask him to review this patient. Remember to request immediate review if the patient is very unwell. |

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23 Page 21, PGPPP (Practice) Guidelines for the supervision and training of doctors in the Prevocational General Practice Placements Program, November 2010