

## Purpose

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.

## Scope

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.<sup>1</sup>

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.

## Key Outcomes

All Victorian Health Services with accredited intern posts and approved PGY2 posts must ensure the supervision requirements outlined in this guideline are fully met.

## Definitions

**Internship**<sup>2</sup> (1<sup>st</sup> year junior doctors) 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** (2<sup>nd</sup> 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.

**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<sup>3</sup> 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

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<sup>1</sup> Particularly in relation to the accreditation standards listed

<sup>2</sup> MBA Intern Registration Standard

<sup>3</sup> With the Medical Board of Australia

supervisor in the unit that they have the necessary skills, capabilities and experience to undertake such a supervisory role.<sup>4</sup> 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.

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

**Director of Clinical Training (DCT):** A medical practitioner who oversees the training and education provided to junior doctors at a health service/other. Where relevant, the DCT may incorporate the SIT role or liaise with and support the SIT.

*Refer to PMCV SIT/DCT Position Description Guidelines for credentials and role.*

**Term Supervisor** is a medical practitioner designated to be 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 need to have the ability to monitor the wellbeing of junior doctors under their care. Term Supervisors must have registration with the Medical Board of Australia and not have any imposed restrictions on their practice by AHPRA. A Term Supervisor should be allocated for each junior doctor rotation/term. *Refer to PMCV Term Supervisor Position Description Guidelines for detail on credentials and role.*

#### 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.

### *Other relevant standards*

3.1.3	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.
4.2	The facility provides for interns/PGY2s to attend formal education sessions, and ensures that they are supported by senior medical staff to do so.
5.2.1	The facility provides regular, formal and documented feedback to interns/PGY2s on their performance within each rotation.
5.2.3	Interns/PGY2s receive timely and progressive informal feedback from clinical supervisors during every rotation.
5.2.5	The facility has clear procedures to address immediately any concerns about patient safety related to the performance of interns/PGY2s.
7.2.2	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.

<sup>4</sup> 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

# Procedure

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<sup>5</sup>.
2. The training program has clear procedures to address immediately any concerns about patient safety related to the performance of junior doctors.<sup>6</sup>
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.<sup>7</sup>

*For clinical supervisors:*

8. Clinical supervisors are aware of their responsibilities in providing clinical supervision.
9. Clinical supervisors have the necessary skills and competencies<sup>8</sup> to provide clinical supervision.<sup>9</sup>
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.<sup>10</sup>

## Junior Doctor Participation in the Patient (Informed) Consent Process

These statements clarify supervisor responsibilities when requesting that interns or PGY2s obtain informed consent from a patient for an investigation or treatment rather than attempting to define each and every procedure for which junior doctors may obtain informed consent.

The intention is not to limit the clinical experience of junior doctors, as developing skills in obtaining informed consent is essential<sup>11</sup>, but rather to ensure their welfare and the safety of their patients.

For consent to be valid, it must be freely given; specific to the proposed treatment and/or procedure; consistent over a period of time; and given by a person who is legally able to consent. Patients are entitled to make their own decisions about medical treatments or procedures, and should be given adequate information<sup>12</sup> that they understand, and to allow adequate time and opportunity to consider this information in relation to their values, on which to base those decisions. Patient competence (the ability and maturity to understand the proposed treatment) and capacity (the ability to understand the information) is also relevant.

It is the responsibility of the senior medical officer in charge of providing care to a patient to ensure that informed consent for the procedure is obtained from that patient and documented appropriately. The senior medical officer

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<sup>5</sup> Refer **PMCV Guidelines for SIT/DCT and Term Supervisor Position Descriptions**

<sup>6</sup> Clinical supervisors must constantly monitor the performance and wellbeing of junior doctors.

<sup>7</sup> Refer to *PMCV Performance Assessment and Feedback Guidelines for Junior Doctors*.

<sup>8</sup> **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.**

<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> AMC Intern training guidelines for terms, page 4

<sup>12</sup> In regards the proposed treatment, the benefits and risks, side effects, possible complications and any alternatives.

may delegate obtaining the consent to an appropriate member of the medical team caring for the patient, provided the person is suitably qualified and trained and has sufficient knowledge of that investigation or treatment, however the senior medical officer remains responsible for the consent.

1. Supervisors<sup>13</sup> must ensure junior doctors understand the principles of 'informed consent'<sup>14</sup> particularly in regard to providing a full explanation of the benefits and risks involved and patient capability to provide consent.
2. For interns, the focus should be on understanding the principles of obtaining valid consent. Supervisors may entrust interns with the responsibility to obtain consent for some investigations and treatments, once the supervisor is confident that they are competent to do so (*usually following observation by a supervisor*). **Interns should not be responsible for consenting patients for surgery or other operating room procedures.**
3. Interns should always feel comfortable to decline if they feel unprepared/unsupported in obtaining consent without any fear of recrimination or consequences.
4. PGY2s should not obtain informed consent for a procedure or operation unless they have observed the procedure, understand the risks involved and are able to assess the patient's capacity to make an informed decision, and have access to supervisor support should they have concerns about consenting a patient for a procedure. Their understanding of the risks, and ability to assess the patient's capacity to make an informed decision, must be observed by the supervisor and deemed as competent to obtain informed consent.
5. Interns and PGY2s should not be responsible for making resuscitation or end of life decisions. Whilst it is necessary for their training for junior doctors to observe and be involved (when appropriate) in these discussions, this should always be in the presence of, or after discussion with, the clinical supervisor. The outcome must be approved by a senior clinician within 24 hours and there is an expectation that if the decision is contentious at all a more senior clinician would be available to be present and assist either in the assessment, decision making or discussion with patient/family.

## 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.*<sup>15</sup>

1. There is a nominated Term Supervisor<sup>16</sup> 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<sup>17</sup>).
  - a. Junior doctors have interaction with the Term Supervisor/ senior medical staff in the unit at least once per week.<sup>18</sup>

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<sup>13</sup> Senior Medical Officer – Consultant/ Registrar

<sup>14</sup> Refer Section 3.5 of the *Good medical practice: a code of conduct for doctors in Australia*

<sup>15</sup> **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**

<sup>16</sup> **Not necessarily the same for every junior doctor in the unit.** Refer definition on page 2 and Appendix B. **There should be a specific position description (refer *PMCV Term Supervisor Position Description Guidelines*).**

<sup>17</sup> 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.

<sup>18</sup> 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).

- 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<sup>19</sup> and supervised to provide safe and effective handover.<sup>20</sup>
  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.<sup>21</sup>
- 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 maximise patient safety and opportunities for clinical learning.<sup>22</sup>
  - b. All patients seen by interns must be reviewed by a clinical supervisor<sup>23</sup> prior to discharge.
  - c. For PGY2s supervision may be direct or indirect (although supervisor must be readily available) depending on the complexity and acuity 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 FACEM, 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).

It is reasonable for interns and PGY2s to undertake seclusion reviews and mechanical restraint reviews provided they have had appropriate orientation and training in protocols and escalation processes.

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<sup>19</sup> Orientation should include direct interaction with senior clinical supervisor to discuss the medical expectations of the unit.

<sup>20</sup> 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.

<sup>21</sup> Northern Health policy

<sup>22</sup> 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*

<sup>23</sup> With appropriate experience in emergency medicine

Further, junior doctors must understand the procedure and feel comfortable to undertake the seclusion review. Care needs to be taken that these requirements are met when interns or PGY2s are asked to perform these reviews after hours/on cover shifts.

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.

### General Practice terms<sup>24</sup>

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 including consulting sessions with supervisor.

The junior doctor will then progress through various stages of training as they develop increasing clinical independence in the general practice setting.

**Interns would usually complete the observation and second stage of training during a term.** All activities undertaken by interns must be supervised.

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<sup>25</sup>** involves the supervisor and the junior doctor undertaking patient consultations consecutively with direct supervisor feedback given at the conclusion of EACH patient consultation. This feedback would include discussion with the patient and the junior doctor (learner) and case based learning either during or after completion of the consultation.

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 A for training plan example.

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<sup>24</sup> Adapted from PGPPP (Practice) Guidelines for the supervision and training of doctors in the Prevocational General Practice Placements Program, November 2010

<sup>25</sup> 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>

### *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.

## Version Control

*Version approved along with date of next review.*

Version	Amendments by	Changes	Date
<b>12</b>	Accreditation Committee	Review of JMO participation in <i>Goals of Care Resuscitation Status</i> discussions/ documentation	20 August 2020
11	Accreditation Committee	Update to Psychiatry Supervision requirements (seclusion reviews)	18 May 2020
	Accreditation Committee	Update of Statement on Junior Doctor Participation in Patient (Informed) Consent Process and update to Term Supervisor Credentials	August 2019
	Accreditation Committee	Statement on informed consent	18 March 2019
	Accreditation Committee	Guideline revised as statements	July 2016
Initial		New guidelines approved by PMCV Board	April 2012

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Approved by: PMCV Accreditation Committee

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Next Review: 2023 (or as required)

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Date: 20 August 2020

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## Appendix A<sup>26</sup>

**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.

<p><b>Low risk scenarios:</b></p> <p>Daily consultations where John feels confident of his management approach eg</p> <p>URTIs in children</p> <p>Most nursing home visits</p> <p>Acute sporting injuries and minor trauma</p>	<p><b>Strategies:</b></p> <p>stage 3 approach, reviewing each patient at the end of the session.</p> <p>Requesting assistance "on the spot" as needed</p>	<p><b>How to access support</b></p> <p>Phone supervisor</p> <p>Phone advanced registrar for low risk questions</p> <p>Notify supervisor by messaging</p> <p>Seek nursing support as needed</p> <p>Use Therapeutic Guidelines</p> <p>Consult Murtagh</p>
<p><b>Moderate risk scenarios:</b></p> <p>Where John feels unsure of his approach or in the following scenarios</p> <p>Chronic disease consultations, especially care planning</p> <p>Mental health consultations</p> <p>Children who require medication (eg otitis media, moderate croup)</p> <p>Antenatal care</p>	<p><b>Strategies:</b></p> <p>Stage 2 approach, reviewing the patient before they leave the consulting room</p>	<p><b>How to access support</b></p> <p>Phone/message supervisor and ask him to review this patient</p>
<p><b>High risk scenarios:</b></p> <p>Where the patient is at high risk</p> <p>Any consultation where the diagnosis is unclear and the patient is unwell</p> <p>Any seriously ill child</p> <p>Any immunisation (prior to giving the vaccine)</p> <p>Any neonate</p> <p>Any patient who expresses suicidality</p> <p>Any patient where you feel unsafe or worried</p>	<p><b>Strategies:</b></p> <p>Stage1 approach, reviewing the patient together</p>	<p><b>How to access support</b></p> <p>Phone/message supervisor and ask him to review this patient. Remember to request immediate review if the patient is very unwell.</p>

<sup>26</sup> Page 21, PGPPP (Practice) Guidelines for the supervision and training of doctors in the Prevocational General Practice Placements Program, November 2010