PMCV Clinical Supervision for Prevocational Doctors Guidelines 2024

Purpose

The purpose of these guidelines is to ensure that facilities and supervisors are aware of the clinical supervision requirements for prevocational doctors (PGY1/PGY2) to promote the provision of safe patient care and prevocational doctor wellbeing.

Key Outcomes

All Victorian Health Services with accredited PGY1 and PGY2 posts must ensure the clinical learning requirements outlined in this guideline are fully met.

Scope

Assessment of the clinical supervision provided to prevocational doctors, in conjunction with the *PMCV Clinical Learning for Prevocational Doctors Guidelines,* is a key component of prevocational medical training accreditation.

These guidelines apply to all Victorian prevocational medical training facilities. Prevocational doctors are defined as medical graduates in their first two years of clinical practice, specifically PGY1s and PGY2s.

Definitions

PGY1 A doctor in their first postgraduate year (PGY1) and who holds provisional registration with the Medical Board of Australia.

PGY2 doctors (2nd year prevocational 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.

Prevocational Training Program A period of two years of generalist, work-based, clinical training after graduation. Each year (PGY1 or internship, and PGY2) comprises 47 weeks of supervised clinical training that meets the requirements set out in the National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms. Each year of the program includes orientation, formal and informal education sessions, and assessment with feedback, and may be provided by one or more training providers.

Clinical supervisors A medical practitioner who supervises the prevocational doctor while they are assessing and managing patients.

- Primary clinical supervisor(s) – is the supervisor with consultant level responsibility for managing patients in the relevant discipline that the prevocational doctor is caring for. The consultant in this role might change and could also be the term supervisor.
- Clinical supervisor(s) (day-to-day) is an additional supervisor who has direct responsibility for patient care, provides informal feedback, and contributes information to assessments. This occurs in many settings, and the person in this role should remain relatively constant during the term. They should be at least PGY3 level, such as a registrar.

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 program provided to PGY1s in a training program.

Director of Clinical Training (DCT) (or Equivalent): A senior clinician with delegated responsibility for developing, coordinating, promoting and evaluating the prevocational training program at all sites. This clinician also has an important role in longitudinal oversight, advocacy and support of prevocational doctors within the program. In fulfilling the responsibility of this role, the DCT will regularly liaise with term supervisors, MEOs and prevocational medical officer (JMO) manager(s), the DMS and others involved in the prevocational training program. The role has a range of titles in different jurisdictions and training sites, including director of prevocational education and training (DPET), and may interact with a supervisor of intern training, who has primary responsibility for PGY1 doctors (interns). Other titles may be used in community health settings, including general practice.

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

Term Supervisor The person responsible for orientation and assessment during a particular term. They may also provide primary clinical supervision of the prevocational doctor for some or all of the term. A Term Supervisor should be allocated for each prevocational doctor rotation/term. *Refer to PMCV Term Supervisor Position Description Guidelines for detail on credentials and role.*

Accreditation Standards

Supervision specific standards

3.2.1	Prevocational doctors are supervised at all times at a level and with a model that is appropriate to their experience and responsibilities.
3.2.2	Prevocational supervisors understand their roles and responsibilities in assisting prevocational doctors to meet learning objectives and in conducting assessment processes.
3.2.3	Supervision is provided by qualified medical staff with appropriate competencies, skills, knowledge and a demonstrated commitment to prevocational training.
3.3.1	Staff involved in prevocational training have access to professional development activities to support quality improvement in the prevocational training program.
3.3.3 / 5.1.1	The prevocational training program regularly evaluates the adequacy and effectiveness of prevocational doctor supervision. The prevocational training provider regularly evaluates and reviews its prevocational training program and terms to ensure standards are being maintained. Its processes check program content, quality of teaching and supervision, assessment, and prevocational doctors' progress.

Other relevant standards

1.3.7	The prevocational training program provides regular, formal and documented feedback to prevocational doctors on their performance within each term.
2.4.1	The prevocational training program provides regular, formal and documented feedback to prevocational doctors on their performance within each term.
2.4.3	The prevocational training program documents the assessment of the prevocational doctor's performance consistent with the Training and assessment requirements. Additionally in PGY1, the assessment documentation is consistent with the Registration standard – Granting general registration on completion of intern training.
3.4.3	The training program provides and enables for prevocational doctors to participate in formal program and term orientation programs, which are designed and evaluated to ensure relevant learning occurs.
3.4.4	The health service ensures protected time for the formal education program, and ensures that prevocational medical doctors are supported by supervising medical staff to attend.
4.2.3	The duties, rostering, working hours and supervision arrangements of prevocational doctors are consistent with the National standards and requirements for programs and terms and in line with principles of delivering safe and high-quality patient care.

Procedure

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

Clinical Governance (overall training program)

The employer is ultimately responsible for ensuring that prevocational doctors are appropriately supervised to providesafe 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 prevocational doctors.
3. The adequacy and effectiveness of supervision of prevocational doctors is evaluated.

For prevocational doctors:

4. Prevocational 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 prevocational 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 prevocational doctor training.

Prevocational Doctor Participation in the Patient (Informed) Consent Process

These statements clarify supervisor responsibilities when requesting that PGY1s or PGY2s obtain informed consent from a patient for an investigation or treatment rather than attempting to define each and every procedure for which prevocational doctors may obtain informed consent.

The intention is not to limit the clinical experience of prevocational doctors, as developing skills in obtaining informed consent is essential, 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 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 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 must ensure prevocational doctors understand the principles of 'informed consent' particularly in regard to providing a full explanation of the benefits and risks involved and patient capability to provide consent.
2. For PGY1s, the focus should be on understanding the principles of obtaining valid consent. Supervisors may entrust PGY1s 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*). **PGY1s must not be responsible for consenting patients for surgery or other operating room procedures**.
3. PGY1s 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. PGY1s and PGY2s must not be responsible for making resuscitation or end of life decisions, although PGY2s could commence the process once appropriately trained. Whilst it is necessary for their training for prevocational doctors to observe and be involved (when appropriate) in these discussions, this should

always be in the presence of (for PGY1s), or after discussion (for PGY2s), 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 PGY1s/PGY2s must be consistent with the delivery of safe patient care and provide a safe learning environment.

1. There is a nominated Term Supervisor with the required skills and qualifications.
2. The Term Supervisor introduces themselves to the prevocational doctor at the commencement of the rotation and undertakes a Beginning of Term Discussion to discuss the goals of the rotation and outline the expectations.
3. The Term Supervisor ensures that their contact with each prevocational doctor is sufficient to allow an effective assessment of the prevocational doctor's performance at mid- and end-term and provide formal feedback in a meeting with the prevocational doctor.
4. There is a clinical supervisor with the appropriate capabilities and experience identified for each patient for the prevocational doctor at ALL times and that all prevocational doctors know who their immediate clinical supervisor is for every patient. For PGY1s, a clinical supervisor must be awake and onsite at all times (i.e., direct supervision) and for PGY2s clinical supervisors may be offsite but must be easily contactable and available onsite within 10 minutes (i.e., indirect supervision).
5. Clinical supervisors in the unit regularly monitor the performance and wellbeing of prevocational doctors and are aware of processes to support prevocational doctors in distress.
6. Prevocational doctors are rostered more time with consultant supervision than when there is less supervision(ideally no more than 30% of rostered time afterhours).
    a. Prevocational doctors have interaction with the Term Supervisor/ senior medical staff in the unit at least once per week.
    b. Prevocational doctors have regular (daily for PGY1s) contact with, and informal feedback from, an appropriate clinical supervisor (including registrars).
    c. 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.
7. Prevocational doctors are adequately oriented and supervised to provide safe and effective handover.
8. PGY1s 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.
9. **For emergency terms:**
    a) A clinical supervisor must be available to supervise the prevocational 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.
    b) All patients seen by PGY1s must discuss each case with a clinical supervisor prior to admission or discharge.
    c) PGY1s must not be expected to manage obstetric patients or children less than two years of age without direct supervision.

d) 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.
e) At no time should PGY1s be the sole doctor in the emergency department.
f) PGY1s and PGY2s 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.

Supervision requirements for PGY1s and PGY2s in specific terms

Psychiatry terms

PGY1s and PGY2s, particularly those with no prior experience in psychiatry, should be supervised by an appropriate clinical supervisor (psychiatrist or registrar) at all times. PGY1s and PGY2s should not be the only doctor on the ward.

In particular, PGY1s/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. PGY1s 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. PGY1s may not attend Mental Health 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 PGY1s and PGY2s to undertake seclusion reviews and mechanical restraint reviews provided they have had appropriate orientation and training in protocols and escalation processes.

Further, prevocational doctors must understand the procedure and feel comfortable to undertake the seclusion review. Care needs to be taken that these requirements are met when PGY1s 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 PGY1 and PGY2 posts in Victoria. Further, it would be appreciated if facilities could review their psychiatry terms for PGY1s and PGY2s to ensure that these requirements are being met.

General Practice terms

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

Prevocational supervision – a phased approach

It is recommended that all prevocational doctors, both PGY1 and PGY2, commence their rotation at phase 1 and transition to phase 2 and 3 as deemed appropriate by the Delegated/Principal Supervisor. The phases are defined as:

Phase 1: Prevocational doctor shadows supervisor

Phase 2: Supervisor physically reviews each patient seen by the prevocational doctor

Phase 3: Supervisor discusses each patient with the prevocational doctor

The last part of the consultation, usually a 15-minute slot, allows the prevocational doctor to discuss the patient with the Delegate/Principal/Term Supervisor or other accredited supervisor. The Supervisor will then determine the need for physical review (always in Phase 2 and by discretion in Phase 3). This enhances patient safety and provides feedback to the prevocational doctor on this consultation. It is expected that the prevocational 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 prevocational 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 therelevant assessment form) to be forwarded to the parent health service.

Refer to PMCVs *Guidelines for Prevocational Medical Training in the GP Setting* for further information.

On-call & After Hours in General Practice

PGY1s 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.

References

These national standards relate to the Medical Board of Australia's registration standards in two important areas:

- **General registration.** The standards for PGY1 align with the Medical Board of Australia's Registration standard – *Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of PGY1 training*
- **CPD exemption for mandatory registration standards.** The Medical Board of Australia's revised Registration standard: *continuing professional development* will come into effect on 1 January 2023. As provisionally registered doctors, PGY1 doctors are exempt from further continuing professional development (CPD) requirements. PGY2 doctors undertaking a structured program leading to a certificate of completion will also be exempt from additional CPD requirements.

Version Control

Version approved along with date of next review.

Version	Amendments by	Changes	Date
14	Accreditation Committee	Updates in-line with NFPMT implementation	27 Aug 2024
13	Accreditation Committee	Review of wording and item 8b	21 June 2021
12	Accreditation Committee	Review of JMO participation in *Goals of Care Resuscitation Status* discussions/ documentation	20 August 2020
11	Accreditation Committee	Update to Psychiatry Supervision requirements (seclusion reviews)	18 May 2020
	Accreditation Committee	Update of Statement on Prevocational 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

Approved by PMCV Accreditation Committee

Next Review 2026 (or as required)

Date June 2024