ACRRM

Fellowship Supervisor

GUIDE

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming.

We recognise these lands and waters have always been a place of teaching, learning, and healing

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1. Introduction

The supervisor is the cornerstone of the apprenticeship model used in the Fellowship Training Program. As doctors progress towards Fellowship of the Australian College of Rural and Remote Medicine (ACRRM) the supervisor ensures that safe, confident and independent doctors emerge as Fellows of ACRRM.

This guide has been developed for doctors providing (or intending to provide) supervision of doctors progressing to Fellowship of ACRRM. The guide provides information and guidance on:

- ✓ eligibility criteria to become a supervisor
- ✓ supervisor roles and responsibilities
- ✓ benefits of being a supervisor
- ✓ how to become a supervisor
- ✓ getting your health service ready to train
- ✓ supervisor training and support
- ✓ understanding the Fellowship Training Program
- ✓ supporting your doctor in training with assessment preparation
- ✓ teaching and facilitating learning
- ✓ helping the learner in difficulty
- ✓ further reading

2. Becoming a supervisor

2.1 Supervisor qualifications and experience

Doctors in training are required to have an allocated accredited supervisor throughout training. The specific qualifications and experience required of the supervisor depends on the health service and the stage of training.

The following qualifications and experience apply to all supervisors providing supervision for ACRRM doctors in training. Supervisors are required to:

- hold current registration with the Medical Board of Australia, without any imposed restrictions or conditions.
- for the Core Generalist Training, be a Fellow of ACRRM or have other relevant qualifications and/or experience, as approved by ACRRM
- for the Advanced Specialised Training, be a Fellow of ACRRM with expertise in the AST area, be a Fellow of a Specialist College relevant to the AST, or hold other relevant qualifications and experience.
- demonstrate compliance with their College Professional Development Program

See Supervisor and Training Post Standards on the ACRRM website for further details.

2.2 Supervisor roles and responsibilities

A supervisor's role is primarily to provide oversight, guidance and feedback to a doctor in training on matters of personal, professional and educational development. This includes the requirement to anticipate a doctor's strengths and weaknesses in clinical situations, in order to maximise patient safety.

ACRRM supervisors new to the role are required to complete the ACRRM supervisor modules:

- Foundations of Rural Generalist Supervision: Introduction
- Foundations of Rural Generalist Supervision: Supervision and Teaching
- Foundations of Rural Generalist Supervision: Supervision Placement
- Foundations of Rural Generalist Supervision: In-practice teaching
- Foundations of Rural Generalist Supervision: Consultation Observation and Feedback
- Foundations of Rural Generalist Supervision: Supervisors Problem Case Discussion
- Foundations of Rural Generalist Supervision: Clinical Supervision and Random Case Analysis
- ACRRM Cultural Safety

These modules are designed to provide supervisors with the skills to understand ACRRM's training requirements, including the breadth and scope of knowledge, skills and experience that are required to gain fellowship. By understanding the mandated level of supervision, supervisors can ensure compliance with ACRRM's supervision requirements, commensurate to the doctor in training's level of training. Regular participation in supervisor training will develop supervision, teaching and mentoring skills.

To ensure compliance, supervisors need to:

- Provide/facilitate structured educational activity requirements according to the doctor in training's stage of training and experience, as per ACRRM's educational requirements
- Organise their own clinical workload to be compatible with teaching commitments
- Ensure number of doctors under your supervision does not exceed your ability to provide effective supervision
- Ensure that another supervisor is available when they are not available to the doctor in training
- Provide appraisal and formative assessment of the doctor in training in accordance with their stage of learning and ACRRM requirements

It is important to establish expectations early in the placement process. Meeting with the doctor in training during orientation to discuss and appraise the doctor's skills and experience is an important safety netting strategy and facilitates the development of an effective learning plan. Negotiating methods and frequency of communication with the doctor in training during orientation also facilitates a clarity in expectations, increasing the safety netting process.

It is preferred that ACRRM supervisors hold FACRRM, but it's not mandatory. If you do not hold FACRRM but are interested in becoming one, you may wish to explore the Rural Experience Entry to Fellowship (REEF) program which provides a facilitated, simplified pathway to ACRRM Fellowship for doctors with comparable qualifications and experience.

2.3 What are the benefits of being a supervisor?

Doctors who work as a supervisor find there are many benefits. Supervisors report that providing supervision:

- is enjoyable and provides altruistic satisfaction by giving back to the profession
- helps you to learn how to learn, improving the quality of your own practice by identifying gaps and increasing your knowledge
- keeps your skillset up to date, facilitating additional professional opportunities
- improves the quality of the workplace through sharing knowledge and skills, increased teamwork, and isolation reduction by expanding contacts and networks
- gives you career diversity.

Supervisors may claim an annual professional development (PD) payment in recognition for providing supervision, gaining accreditation as a training post and undertaking the minimum education activities such as the online ACRRM supervisor modules. Supervisors holding a FACRRM may find further information in the ACRRM PDP Handbook. Supervisors holding a Fellowship of other medical colleges should refer to their own professional development program for PD requirements.

2.4 Process to become a supervisor

A training post refers to the accredited health service in which the doctor in training works under supervision. Applying to become a supervisor for ACRRM training is usually incorporated in the process of the training post becoming accredited.

Supervisors generally work at the same site as the doctor in training. However, supervision may contain elements of off-site supervision. The proposed model of supervision must be approved by ACRRM prior to activation. For further information, refer to the remote supervisor guidelines available on the ACRRM website.

The Standards for Supervisors and Training Posts provide information on our accreditation requirements. Refer to our website for the process on becoming an accredited supervisor.

2.5 Reducing risk as a supervisor

Supervisors are recommended to advise their medical defence organisation of their intent to provide supervision, checking they have adequate and appropriate insurance cover.

In addition, for each doctor in training under your supervision, it is recommended that you check:

- the Medical Register to ensure that the doctor in training has current medical registration with no restrictions.
- that the doctor in training has appropriate medical indemnity including run off cover for the term of the appointment. Obtaining a copy of the policy details and a receipt is advisable.
- that there is a written employment contract with the doctor in training covering terms of the appointment.
- your ability to deliver the required the level of supervision and educational delivery commensurate to the registrar's training requirements

2.6 How to get your facility ready to train

Orientation to post

Potential issues in a placement can be mitigated by instituting a detailed orientation process. This should involve the different members of the team and should equip the doctor in training with the knowledge and tools on processes, identifying subject matter experts within the group and establishing preferred communication methodologies. Orientation should also include the local community and referral pathways (refer to ACRRM's CGT Orientation Plan Proforma for more suggestions). This is an opportunity to make the doctor in training to feel welcome and establish safety netting protocols by developing an understanding of the doctor's strengths and learning opportunities.

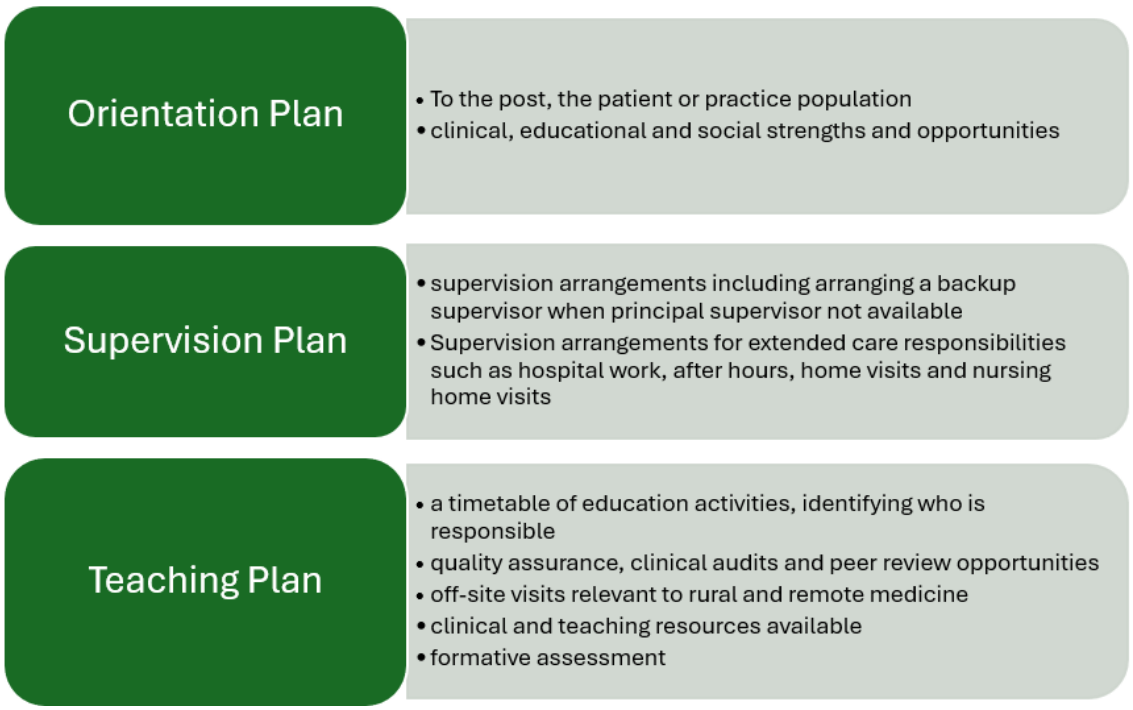
Supervision plan

The supervision plan provides clarity for the doctor in training regarding who, how and when to contact a supervisor for support. Clarity in the communication process reduces stress for the doctor in training and adds a layer of safety netting by establishing clear expectations on when supervisor involvement is required. Refer to the CGT Supervision Plan proforma for more details.

Teaching plan

An important aspect of getting your facility ready is putting together a teaching plan. A teaching plan documents what the facility has to offer a doctor in training, detailing the educational activities available in and outside of the post including clinical resources. Refer to the CGT Teaching Plan proforma for more details.

Having a written plan will assist to ensure that teaching is provided consistently and effectively. See below for a list of things to include in the plan.



3. Supervisor training and support

3.1 Regional Training Network

State based regional teams are strategically based to provide a nuanced approach to support provision that accommodates a localised understanding of the training environment. Contact details are available on the Regional Training Network page.

3.2 Educational Delivery

Online learning

ACRRM online educational resources are available on the ACRRM website to College members and accredited Supervisors. They include a growing selection of interactive courses, case studies and discussion forums. ACRRM hosts several thousand instructive clinical cases and around a hundred courses designed or customised by the College to be relevant to rural and remote medical practice.

Included in the suite of learning opportunities are targeted modules designed to enhance the skillset essential to the role of the supervisor:

Orientation to Fellowship Training – Supervisors

- Familiarisation of ACRRM's Fellowship Training Program
- Understand Fellowship competencies
- Define the role of the supervisor
- Readiness to train registrars

Foundations of RG Supervision: Introduction

- Duality of the supervisor role
- Clinician vs educator
- Task revision through a dual role lens

Foundations of RG Supervision: Supervision and Teaching

- Transitioning from a conceptual to task orientated understanding
- Processes behind educational delivery
- Theoretical to practical – best practice principle

Foundations of RG Supervision: Supervision Placement

- The importance of the orientation process
- Recommended tasks
- Provision of resources and tools

Foundations of RG Supervision: Consultation Observation and Feedback

- Providing feedback on observed consultations
- The importance of this tool in protecting patient safety

ACRRM Cultural Safety

- Develop introductory knowledge and insight into Aboriginal and Torres Strait Islander Peoples' beliefs, values, histories, cultures and experiences

Additional online modules foster an enhanced understanding of ACRRM's training assessments.

MiniCEX

- 4 hours
- Nil cost

Multiple Choice Question (MCQ)

- 2 hours
- Nil cost

Structured Assessment using Multiple Patient Scenarios (StAMPS)

- 2 hours
- Nil cost

The following are some of ACRRM's frequently accessed resources:

150 Shades of Radiology	• 150 online cases mapped against a condition index
Allergy Assist	• Free expert allergy advice and education from clinical/immunology specialists within 48 hours
Connect@ACRRM	• Discussion forum for peer networking
Life Hacks Podcast	• Covering a diverse range of topics in an easy conversational format.
Rural EM Forum	• Presentation of new and challenging cases every 3 weeks to help with clinical management decision. • Members only
Tele-Derm	• Free expert dermatological advice within 48 hours and access to over 3000 cases

Workshops

Hosted by ACRRM and the Rural Doctors Association of Australia, Rural Medicine Australia (RMA) delivers a blend of professional development with networking connection opportunities relevant to ACRRM supervisors.

The College's wider program of face-to-face training workshops delivered in locations across the country support skills development in diverse areas of rural medical practice. Information on these is available at the College website.

3.3 Additional Organisations

ACRRM works collaboratively with a diverse range of organisation to deliver support to our supervisors and training organisations.

General Practice Supervisor Association (GPSA)

General Practice Supervisor Association (GPSA) is the national representative body for general practitioner supervisors. GPSA is supported by funding from the Australian Government under the Australian General Practice Training Program (AGPT). Membership is free.

The GPSA aims to:

- Lobby and work with relevant health sector policy makers and representatives to make supervision rewarding, respected and recognised.
- Work with members, GPs and the health sector to increase the recruitment and retention of quality supervisors.
- support supervisors in their roles and professional development
- Negotiate the National Terms and Conditions for the Employment of Registrars (NTCER) between supervisors and doctors in training on behalf of supervisors.

GPSA has a wide range of downloadable resources publicly available, including a series of teaching plans.

Joint Colleges Training Services (JCTS)

Created in 2022 as a joint venture of ACRRM and the Royal Australian College of General Practitioners (RACGP), Joint Colleges Training Services (JCTS) works closely with supervisors and registrars through the provision of ongoing cultural mentorship, training and education.

Remote Vocational Training Scheme (RVTS)

Remote Vocational Training Scheme (RVTS) is the only remaining training organisation that accredits Training Posts on ACRRM behalf. They are accredited by ACRRM to manage keys aspects of the College training program including provision of orientation, training and support for supervisors.

4. Understanding ACRRM Fellowship Training Program

4.1 Definitions of practice and Fellowship

The ACRRM curriculum takes a unique approach to describing the essential skills for general practice which the College holds to be consistent with delivering best practice rural general practice and rural generalist medicine.

General Practitioner:

The General Practitioner is the doctor with core responsibility for providing comprehensive and continuing medical care to individuals, families and the broader community. Competent to provide the greater part of medical care, the General Practitioner can deliver services in the primary care setting, the secondary care setting, the home, long-term residential care facilities or by electronic means – wherever and however services are needed by the patient within their safe scope of practice.

Fellows of ACRRM receive specialist registration as a General Practitioner with the Medical Board of Australia and can practise in any location throughout Australia. ACRRM's curriculum and training program prepares doctors to be Rural Generalist medical practitioners

Rural Generalist Practitioner:

A Rural Generalist medical practitioner is a General Practitioner who has specific expertise in providing medical care for rural and remote or isolated communities. A Rural Generalist medical practitioner understands and responds to the diverse needs of rural communities. This includes:

- applying a population approach,
- providing safe primary, secondary and emergency care,
- provision of culturally engaged Aboriginal and Torres Strait Islander peoples' health care as required, and
- providing specialised medical care in at least one additional discipline.

Rural Generalist Medicine:

Rural Generalist Medicine is the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:

- Comprehensive primary care for individuals, families and communities
- Hospital inpatient care and/or related secondary medical care in the institutional, home or ambulatory setting
- Emergency care
- Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues
- A population health approach that is relevant to the community
- Working as part of a multi-professional and multidisciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.

(From the Cairns International Consensus Statement on Rural Generalist Medicine, World Summit on Rural Generalist Medicine, Cairns, 2014.)

ACRRM Fellowship (FACRRM):

A Fellow of ACRRM (FACRRM) is a medical specialist who has been assessed as meeting the requisite standards for providing high-quality Rural Generalist medical practice. This involves being able to:

- provide and adapt expert primary, secondary, emergency and specialised medical care to community needs
- provide safe, effective medical care while working in geographic and professional isolation
- work in partnership with Aboriginal, Torres Strait Islander peoples and other culturally diverse groups and
- apply a population approach to community needs.

4.2 Fellowship Training Program

Core Generalist Training:

- Minimum: 3 years
- Commencing: PGY 2 +

Core Generalist Training (CGT) covers:

- developing broad generalist knowledge, skills and attributes in primary, secondary and emergency care in a rural and remote context, and
- fostering essential rural generalist knowledge and skills in paediatrics, obstetrics and anaesthetics.

Training	Education	Assessment

• Primary Care*:
  • 6 months pre S2.2025
  • 12 months post S2.2025
• Secondary inpatient care: 3 months
• Emergency care: 3 months
• Rural or remote practice: 12 months
	• Education program as specified by the College
	• Rural Emergency Skills Training (REST) and other emergency course/s
	• Advanced Life Support (ALS2)
		•Supervisor reports: 6-monthly
		•9 x Mini Clinical Evaluation Exercises (MiniCEX)
		•Multi-Source Feedback (MSF)
		•Multiple Choice Question (MCQ)
		•Case Based Discussion (CBD)
		•Structured Assessment using Multiple Patient Scenarios (StAMPS)
		•Procedural Skills Logbook (logbook)

* *Registrars commencing on the ACRRM's training program from Semester 2, 2025 onwards are required to complete 12 months minimum in a primary care setting.*

Advanced Specialised Training:

- Minimum: 1 year
- Commencing: PGY 3 +

Advanced Specialised Training (AST) covers:

- building on the core generalist competencies and increasing knowledge and skills in a procedural or non-procedural discipline
- in a specialised area relevant to the needs of rural communities
- to allow autonomous delivery in a defined scope of specialist clinical practice.

Training	Education	Assessment
•Training completion in at least one AST discipline •Refer to the AST web page on ACRRM's website for more information	•Education program provided by the training post •Course requirements specific to each discipline, as outlined in the AST handbooks located on the AST web page on ACRRM's website	•Supervisor reports: 3-monthly •Work based and external assessments specific to the AST discipline •Refer to the ACRRM AST web page for discipline related assessment information

Detailed information on training requirements is located in the Fellowship Training Handbook.

4.3 Rural Generalist Curriculum

Available on the College website, the ACRRM Rural Generalist Curriculum outlines the construct of Rural Generalist Medicine, describing the competencies, knowledge, skills and attributes required to be a Rural Generalist. The curriculum informs the training, education and assessment requirements to achieve Fellowship. An understanding of the curriculum contributes toward implementation by supervisors of effective teaching strategies.

The Curriculum competencies are structured under the eight domains of rural and remote practice.

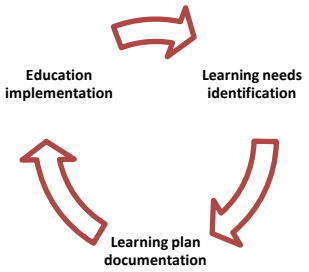
1. Provide expert medical care in all rural contexts
2. Provide primary care
3. Provide secondary medical care
4. Respond to medical emergencies
5. Apply a population health approach
6. Work with Aboriginal, Torres Strait Islander, and other culturally diverse communities, to improve health and wellbeing
7. Practise medicine within an ethical, intellectual and professional framework
8. Provide safe medical care while working in geographic and professional isolation

The curriculum consists of Core Generalist and Advanced Specialised components. Registrars must demonstrate meeting all competencies at the Core Generalist standard, choosing one specialised area in which they demonstrate meeting the competencies at the Advanced Specialised standard.

These standards are described in the Curriculum which also details the knowledge, skills and attributes in 37 clinical and non-clinical Learning Areas. The Learning Areas all include Core Generalist content with Advanced Specialised content included for the approved AST disciplines.

4.4 Learning plan

Doctors in training are encouraged to plan their learning. Ideally registrars will work with their supervisor early in training to document a learning plan, updating the plan as training progresses.



Learning objectives are best selected and referenced against the curriculum to assist the doctor in training to track progress. Supervisors are encouraged to discuss with the doctor in training how this placement can assist in meeting their training requirements, learning objectives and procedural skills logbook. There should also be a discussion and agreement about time off to attend educational activities and emergency courses.

Supervisors should encourage doctors in training to use ACRRM online courses to fill gaps in learning.

4.5 Training plan

Doctors in training are required to have a documented training plan to plot the sequencing and timing of training and assessment. The doctor in training will review their training plan with a Medical Educator.

Supervisors are encouraged to view and discuss the training plan with their registrars to see when assessments are planned. The training plan will identify any gaps the doctor in training may have at training commencement, for example experience in Obstetrics and Gynaecology, Anaesthetics or Paediatrics. Doctors may fill these gaps through undertaking education activities, recording relevant cases and submitting a supervisor report. The template for logging cases and a supervisor report are provided.

Further information may be found in the Fellowship Training Handbook.

4.6 Assessment blueprint

The Fellowship Assessment handbook provides information regarding:

- Assessable learning outcomes as defined in the ACRRM Rural Generalist curriculum and
- The assessment blueprint details mapping learning outcomes to assessment modalities.

While the assessments are undertaken progressively, the standard set for all assessments is that of **a safe, confident and independent general practitioner** able to work across a full and diverse range of healthcare settings in Australia, including rural and remote settings.

4.7 Assisting the doctors in training with assessment

The best preparation is to provide the doctor in training with exposure to the broad scope of practice as described in the curriculum, reinforcing and enhancing this by using the teaching activities outlined later in this resource.

Doctors in training have a range of assessments to complete, in the workplace and by ACRRM. The table below provides information on each assessment and how supervisors may assist.

MiniCEX	
Performed by:	Supervisors and Medical Educators
Usage:	Use the miniCEX forms each time you observe and provide feedback to a doctor in training
Resources:	MiniCEX training course for clinicians (online course) MiniCEX forms
Physical Examination (as part of the MiniCEX)	
Performed by:	Supervisors and Medical Educators
Usage:	Include observation of physical examination in observed consults
Resources:	Formative miniCEX Physical Exam Reference

Procedural Skills Logbook

Performed by: Skills are certified by a doctor at the rank of at least Senior Registrar

Usage: Check what procedures are required by the doctor in training
- Call the doctor in training if procedure is performed in the facility
- Guide doctor with the procedure
- Certify completion of procedure

Resources: Rural Generalist Curriculum

Multi Source Feedback (MSF)

Performed by: CFEP Surveys involving colleagues and patients

Usage: Discuss the MSF report once completed.
- Encourage to undertake early in training when established in a general practice.
- Note there should be no surprises in the feedback provided by supervisors in MSF as highlighted areas should have been previously discussed.

Resources: CFEP Multi-Source Feedback guide

Multi Choice Questions (MCQ)

Performed by: ACRRM

Usage:
- Facilitate a broad range of experiences.
- Discuss assessment readiness with the doctor in training.
- Encourage early and structured preparation for the assessment.

Resources: Introduction to MCQ (online course)

Case Based Discussion (CBD)

Performed by: ACRRM

Usage: CBD must be undertaken in a post that provides continuity of care.
- Conduct regular case-based discussions with the doctor.
- Use the ACRRM forms to structure and document feedback.
- Discuss assessment readiness with doctor in training.
- Assist with choosing suitable cases for summative assessment.
- As the CBD assessment can be conducted in the training facility, assist by providing a venue and invigilator.

Resources: Introduction to CBD Assessment (online course)

Structured Assessment using Multiple Patient Scenarios (StAMPS)

Performed by: ACRRM

Usage: StAMPS should be the last assessment undertaken, after successfully completing the rest of assessments.
- Facilitate a broad range of experience.
- Discuss assessment readiness with the doctor in training.
- Create StAMPS scenarios and have the doctor practice answering them within context of StAMPS community profile and assessment timeframe.
- Encourage participation in a mock exam and study groups to practice assessment technique.

Resources: Introduction to StAMPS Assessment (online course)

5. Guidance for teaching and facilitating learning

5.1 Understanding the learner

Learners have different ways of learning. These may be related to a range of factors including individual, age related, developmental, cultural and generational factors. There are many different models describing learning styles or preferred ways of processing information. A few models are outlined below with the implications they have for teaching and learning described.

5.1.1 Principles of adult learning

Adult learners generally find learning rewarding and use all their senses to learn. They learn more effectively when they can relate new information to their existing knowledge and need opportunities to practise their new skills and apply their new knowledge.

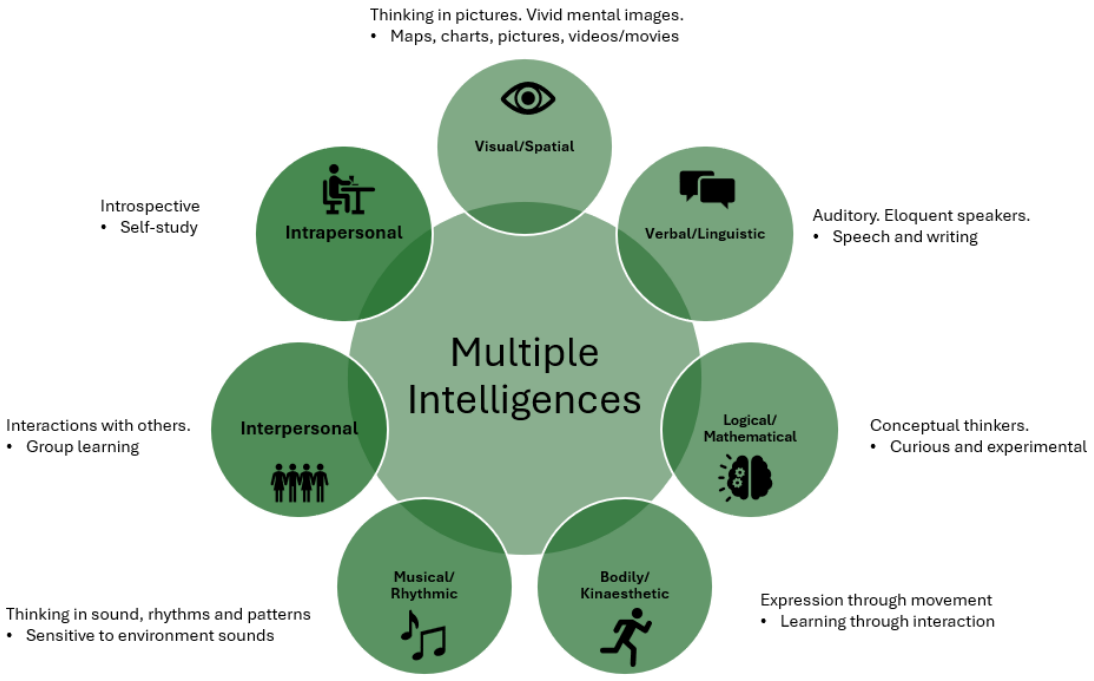
To increase effectiveness of education sessions, adult learners:

1. remember best the first and last things in a learning session
2. need feedback on their progress
3. need to be actively involved in the learning process
4. need time to make sense of and value new information

5.1.2 Individual learning styles

Everyone has a mix of learning styles/intellectual abilities. Some people may find that they have a dominant style of learning; others may find that they use different styles in different circumstances. Styles may also change overtime.

One model called Multiple Intelligences was developed by Howard Gardner. The model describes pathways to learning:



5.1.3 Generational influences

It is most likely that doctors in training will come from a different generation to yourself. This may also have an effect on how they learn.

Baby Boomers **1946 - 1962**

Work hard out of loyalty and expect long term job and pay dues. Self-sacrifice is a virtue. They respect authority.

Influences:	Evidential experts
Teaching focus:	Technical data, evidence
Learning format:	Formal, structured
Learning environment:	Classroom style, quiet
Iconic technology:	TV, audio, cassette
Leaders:	Command, control

Generation X **1963 - 1981**

Work hard if balance allowed. Less likely to put jobs before friends, family, or other interests. Less fixed on titles and status. Less likely to delay gratification. Expect to have many jobs. Question authority.

Influences:	Pragmatic practitioners
Teaching focus:	Practical case studies
Learning format:	Relaxed, interactive
Learning environment:	Round table, relaxed
Iconic technology:	VCR, Walkman, PC
Leaders:	Co-ordination, co-operation

Generation Y **1982 - 2000**

Tech savvy generation. Emotionally uninhibited. Several careers over life. Limitless choice, options a fundamental right.

Influences:	Experiential peers
Teaching focus:	Emotional, participative
Learning format:	Spontaneous, multisensory
Learning environment:	Café, music, multimodal
Iconic technology:	Internet, email, SMS
Leaders:	Consensus, collaborative

5.1.4 Novice to expert scale

The Dreyfus model "Novice to Expert" scale provides a way to understand the progress in the development of skills or competencies and assists in determining the level of supervision required.

	Knowledge	Standard of work	Autonomy	Coping with complexity	Perception of context
Novice	Minimal or 'textbook' knowledge without connecting it to practice	Unlikely to be satisfactory unless closely supervised	Needs close supervision or instruction	Little or no conception of dealing with complexity	Tends to see actions in isolation
Beginner	Working knowledge of key aspects of practice	Straightforward tasks likely to be completed to an acceptable standard	Able to achieve some steps using own judgment, but supervision needed for overall task	Appreciates complex situations but only able to achieve partial resolution	Sees actions as a series of steps
Competent	Good working and background knowledge of area of practice	Fit for purpose, though may lack refinement	Able to achieve most tasks using own judgment	Copes with complex situations through deliberate analysis and planning	Sees actions at least partly in terms of longer-term goals
Proficient	Depth of understanding of discipline and area of practice	Fully acceptable standard achieved routinely	Able to take full responsibility for own work (and that of others where applicable)	Deals with complex situations holistically, decision-making more confident	Sees overall 'picture' and how individual actions fit within it
Expert	Authoritative knowledge of discipline and deep tacit understanding across area of practice	Excellence achieved with relative ease	Able to take responsibility for going beyond existing standards and creating own interpretation	Holistic grasp of complex situations, moves between intuitive and analytical approaches with ease	Sees overall 'picture' and alternative approaches; vision of what may be possible

5.1.5 Creating an optimal learning environment

Regardless of what stage of training the doctor in training is at, he/she will come to a new placement with basic needs. Understanding these basic needs and ensuring that they are met will assist the doctor in training to reach their full potential.

Maslow has argued that for individuals to achieve self-actualisation, that is, to reach their full potential, a range of basic needs have first to be met. Roger Neighbour has articulated 'Hierarchy of Educational Imperatives' for doctors in training. The hierarchy begins with the basic needs of survival, safety, confidence, recognition, self-esteem and ultimately reaching autonomy.

The educational imperatives are defined as:

- "Survival" - includes timetable, protected time, own room, desk, equipment, essential knowledge of local people and arrangements, freedom from personal worries (health, money, housing).

- "Safety" - includes availability of supervisor, information, resources, books, able and willing to ask for help, basic clinical competence, can manage common or simple clinical problems & emergencies.

- "Confidence" - includes feeling like a fully contributing member of the team, can 'hold' a situation, recognise & rectify clinical blind spots, competent with atypical, psychological and social problems.

- "Recognition" - includes attracting personal following of patients, not dependent on supervisor's approval, interested in other aspects (e.g. doctor-patient relationship, consultation skills, hungry for new ideas and experiences).

- "Self-esteem" - includes having a mature trainer-learner relationship, knows and addresses own strengths & limitations, can tolerate uncertainty and occasional failure, can use 'self' in consultations, arranges own educational program.

- "Autonomy" - includes negotiates transition from doctor in training to independent doctor, finds and maintains ways to enhance job satisfaction, takes responsibility for own professional development, sense of worth, purpose and direction.

5.2 Teaching activities

Rural practice is an ideal learning environment, providing many clinical and professional opportunities for learning. Having a structured approach and a teaching plan will assist to ensure that teaching is integrated, efficient and relevant and that teaching requirements are met.

When planning teaching activities consider the following:

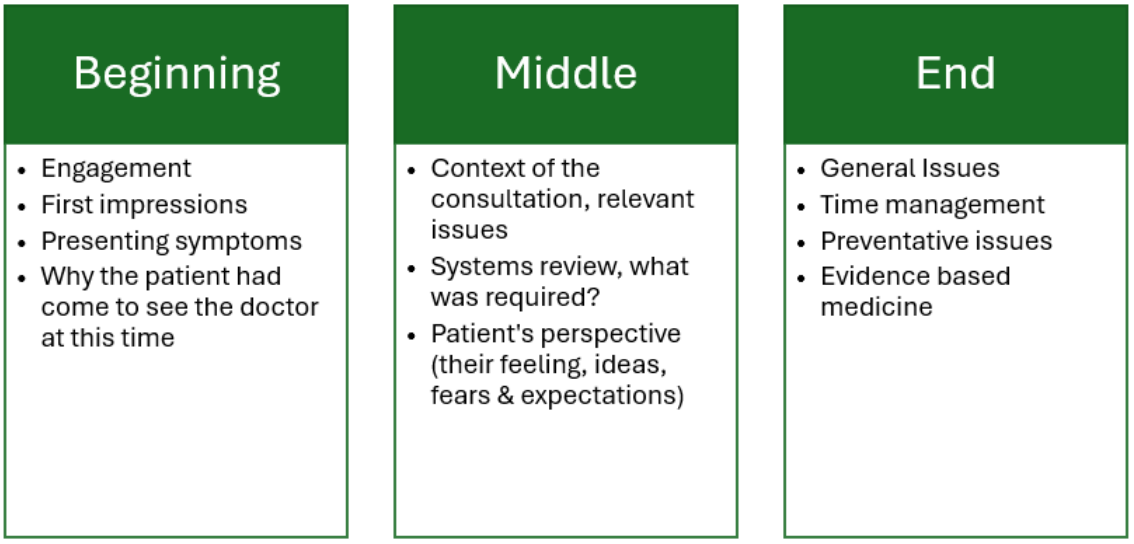
- Learning in isolation or out of context is always hard. If the doctor in training can see a relationship between what they are expected to learn and what they are expected to do, it becomes much easier. Therefore, education should be linked to daily activities such as debriefing after a consultation.
- It is also easier if what they are expected to learn is linked with what they already know.
- The environment and their clinical duties or daily activities should be engineered to optimise learning.
- A range of learning activities should be provided to account for different learning and teaching styles.

Some of the learning activities that might be incorporated into a teaching plan are detailed below.

5.2.1 Case Based Discussion

Doctors in training will be likely to receive the bulk of their clinical teaching through case presentation and discussion. This is particularly the case for interns who are under Level 1 supervision, and so are required to discuss each case. The case discussion process can then follow a thematic pattern.

There are several themes at different stages of the consultation that can often be identified, for example:



Doctors in training should be encouraged to reflect on the cases discussed and to think about how they will address any learning gaps that may have been identified. Supervisors are encouraged to document scoring and feedback using the ACRRM CBD form to enable to doctor to become familiar with the format.

5.2.2 Direct Observation

Observing your doctor in training's consultations, either directly by sitting in or by videotaping and providing feedback on those consultations, should be an integral part of your structured teaching. It is also important for the doctor in training to spend time sitting in with you as this establishes a baseline regarding the consultation process. It is one of the most valuable ways for a doctor in training to learn clinical skills and it is also the only way to really assess how a doctor in training is performing with patients.

If carried out regularly it engenders an environment where reflection on practice is encouraged and allows the supervisor to give specific feedback to the doctor in training that enables them to continue to improve in their clinical performance.

It has been said by educator and philosopher John Dewey that "all learning begins when our comfortable ideas turn out to be inadequate". Through direct observation and feedback, supervisors can create this constructive discomfort and help facilitate learning.

Advantages of direct observation

- √ Able to see how doctor in training performs with patients
- √ Able to assess how doctor in training is progressing over time
- √ Powerful way to teach clinical and consulting skills, displaying attitudes and values
- √ Provision of feedback:
  - insight about their actions
  - Information about the possible consequences
- √ Increases supervisor's knowledge about the doctor in training's skill set

Barriers to direct observation

- ► Lack of time
- ► The patients try to engage the supervisor rather that the doctor in training, undermining the doctor in training
- ► The doctor in training does not like it
- ► The supervisor does not like it

Some tips for successful direct observations sessions:

	**Make Time** Teaching time requires planning. It is important to make direct observation sessions part of the practice culture and to schedule time into the appointment system so that direct observation can occur. Time spent in direct observation is considered in-practice teaching time.
	**Set the scene with the doctor in training** It is helpful to discuss with the doctor in training how these sessions will be conducted and clarify the 'ground rules' for the session, especially for those who may not have been observed before. These sessions are intended to provide the doctor in training with information, examples and strategies for improving their clinical and consulting skills. Supervisor should contact their regional team for support if they identify problems or have significant concerns about the doctor in training's performance.
	**Observing** Placement of the observer's chair out of the line-of-sight of the patient but with a view of the doctor in training encourages focus on the learner not the patient. Avoiding eye contact with the patient helps them to remain engaged with the doctor in training, especially when the patient is known to the observing supervisor. It is also useful not to interrupt the consult unless directly asked by the doctor in training or if the consult becomes unsafe. It is useful to discuss with the doctor in training a plan of action for these situations such as sending the patient to collect a urine sample (if appropriate) or ask the doctor if it is okay to chat outside for a minute. Otherwise, it is better to leave comments and feedback until after the consultation.
	**Giving feedback (see 5.3.1. below for more details)** This is the most important aspect of a direct observation session and, when successful, will enable the doctor in training to improve in future performance.
	**Develop questioning skills** Good questioning is the key to good teaching. Questions that raise the doctor in training's awareness of the clinical process are often the most useful such as: • What do you think is going on here? • What led you to that diagnosis?
	**Learning the skills** The consultation provides the best opportunity to teach a doctor in training the skills of patient centred medicine and for the supervisor to see how the doctor uses these skills during a consultation. As consultation content and process are important, consideration should be given to both when discussing the supervisor's observations.

Supervisors are encouraged to use ACRRM miniCEX forms when scoring and providing feedback on direct observation see Fellowship Assessment Handbook for further information.

5.2.3 Case Audits

This is another form of structured case review. In this session a learning area is identified and then a series of cases are reviewed and discussed with the doctor in training, focusing on the identified learning area.

For example, the doctor in training may identify that they have difficulty in identifying and implementing opportunistic prevention and health promotion. The cases from a day or session could be reviewed with the specific focus being on opportunistic prevention and health promotion. The supervisor could also use role-play to demonstrate the skills in communicating prevention and health promotion to the patient.

Areas of focus could include:

1. Information transfer: clarity of explanations and assessing patient understanding
2. Adherence
3. Being rational: investigations, prescribing, specialist referral and accessing community resources
4. Safety-netting strategies
5. Follow-up processes

5.2.4 Topic tutorials

These can be learner directed or opportunistic. It is appropriate to ask the learner to prepare material for teaching, such as evidence review around a topic, and for the supervisor to overlay that evidence with experience in the rural and remote context. The use of the ACRRM's assessment community profile can assist in providing the rural and remote overlay whilst familiarising the doctor in learning with the community setting.

There are often opportunities through teaching sessions or upskilling with other staff in which the doctor in training can participate in the educational delivery process. Teaching more junior doctors is one example of an opportunity for the doctor in training to consolidate their knowledge base.

The General Practice Supervisors Association has a range of Teaching Plans on common presentations that can be downloaded.

5.2.5 Referral letter review

This is a useful exercise for a teaching session, introducing the concept of the general practitioner as a coordinator of health care for the patient and patient advocacy. The aim is to stimulate discussion about when to use a specialist, reviewing the usefulness of the opinion from the specialist and availability of specialist services in the area.

During this session a copy of the referral letter and the specialist's reply are reviewed together. The supervisor should also bring some of their referral letters to the session as a point of comparison as this can be used to provide feedback to the doctor in training about the content and quality of their referral letters.

Question to consider in the evaluation process include:

1. Was the referral necessary? Consider if the patient could have been managed by the general practitioner and, if so, what knowledge and skills would be needed.
2. Were the specialist's and the doctor in training's findings and conclusions similar? If not, what was different and what does the doctor in training think about this? Have they learnt anything?
3. Were there any investigations arranged by the specialist which the doctor in training has limited knowledge? This could be a learning opportunity.
4. Is there a need for the doctor in training to gain more knowledge about the treatment recommended by the specialist?
5. Was the specialist's opinion helpful in the ongoing management of the patient?
6. What is the doctor in training's involvement in the ongoing management of the patient?

5.2.6 Clinical audit

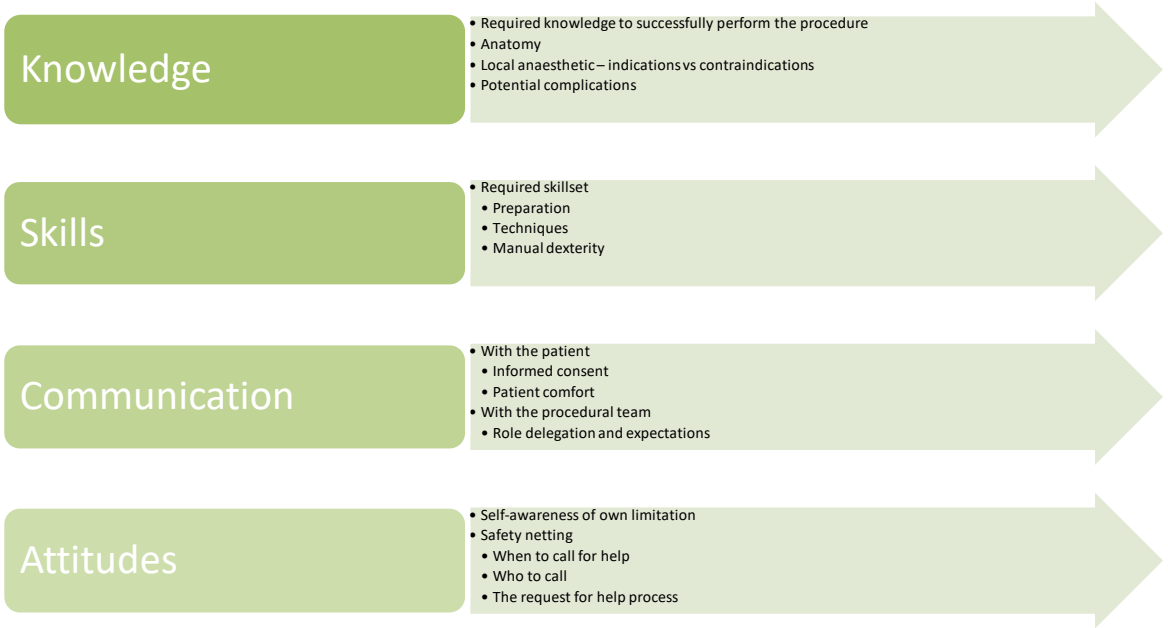
It is useful to introduce the doctor in training to the clinical audit construct. Devoting a teaching session to discussing this would be very useful for the doctor in training as it can increase the doctor in training's awareness of the QA and CPD program activities and the role of clinical audits in training. The doctor in training may be required to complete a clinical audit in a project as part of their training requirements.

This session could also introduce the doctor in training to organisations such as the National Prescribing Service (NPS) through discussion of the various NPS audits in training activities.

5.2.7 Practical procedure teaching sessions

It is always useful to determine a doctor in training's level of exposure to performing procedural skills. Early identification of skill deficits helps to identify learning opportunities in a timely manner and is a good safety measure strategy. For further information on ACRRM Procedural Skills logbook see the Fellowship Assessment Handbook.

There are many skills required to perform a procedure and it is useful to think about these prior to the session.



A useful approach when teaching procedural skills:

1. Discuss the important aspects of performing the procedure with the doctor in training and, if possible, demonstrate using models.
2. Have the doctor in training observe you performing the procedure and then discuss this with the doctor.
    - Have they identified any gaps in their knowledge, skills and/or attitudes?
3. Observe the doctor performing the procedure and provide feedback.
4. Practice the procedure as often as possible.

5.3 Teaching skills

5.3.1 Feedback

Feedback is an essential teaching skill. Feedback should encourage self-reflection, raise self-awareness and help doctors in training plan for future learning and practice. Feedback may be formal or informal. Formal feedback is planned as part of appraisal and assessment and occurs episodically. Informal feedback should be given daily in relation to specific events, for example managing a case or doing a procedure.

When providing feedback:

1. Be timely:
    - Give feedback soon after an event and as regularly as possible (preferably daily or weekly). Waiting till the end of a rotation is too late. Don't give feedback at times when either you or the doctor in training is tired or emotionally charged.

2. Be specific:
    - Give specific feedback with examples, rather than a global "overall, you are doing fine".

3. Be constructive:
    - Help provide solutions for areas of weakness.
    - Give positive critique. Language is powerful. Phrasing such as "what can be improved" rather than "what is wrong" encourages the doctor in training to look for solutions.

4. Depersonalise the message:
    - Speak in the third person rather than the first.

5. Involve attentive listening:
    - Make eye contact with the doctor in training to signal you're listening.
    - Keeping an open posture invites discussion.

6. Focus on the positive:
    - Avoid jokes, hyperbole or personal remarks (concentrate on the act or behaviour, not the person).
    - Try not to dampen positive feedback by qualifying it with a negative statement ("I was very happy with your presentation, Jayne, however . . ."; "Overall, David, we are pleased with your performance, but. . .").

7. Use the feedback sandwich:
    - Give positive feedback before and after constructive feedback.

8. Be in an appropriate setting:
    - Positive feedback is effective when highlighted in the presence of peers or patients.
    - Constructive criticism should be given in private — an office or some neutral territory where you are undisturbed is ideal. Phones should be off the hook, mobiles and pagers turned off.

9. Allow time for discussion or explanation:
    - Doctors in training should be given the chance to comment on the fairness of the feedback and to provide explanations.
    - There may well be circumstances of which you are not aware.

10. Agree on a specific action:
    - Offer help if appropriate.

11. Verify that the message has been heard:
    - For example, say “What is your understanding of what we have just agreed”?

5.3.2 Good questions

Good questioning skills are important for effective teaching. Think about your questioning style, not only what you ask but also how long you wait for a reply.

Higher order	How, why, tell me about, tell me how: develops thinking and reasoning skills
Lower order	What, when: restrict to situations when you need to obtain detail
Pause	Wait up to five seconds to allow for a response
Follow up	Follow a poor answer with another question which returns to the issue
Counter	Resist the temptation to answer learners' questions. Use a counter question instead
Reframing	Use of statements can be less intimidating. “Doctors in training sometimes find this difficult to understand” instead of “Do you understand?”.
Sequencing	Sequence questions to draw out contributions, promoting higher level thinking, developing deeper understanding. For example, “Given your conclusions about the management of this case, how does this influence future management in similar situations?”.

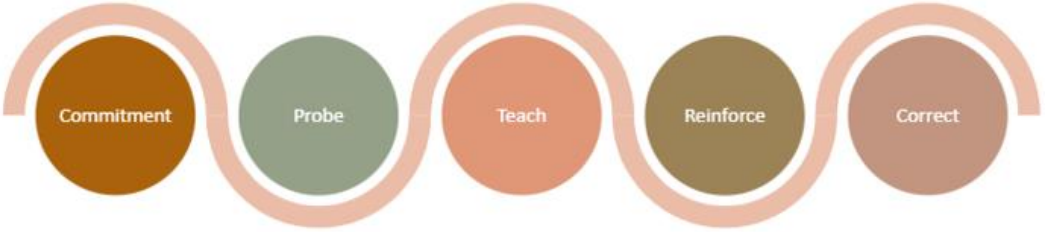
5.3.3 Effective explanations

Providing effective explanations is another important skill check, establishing understanding prior to commencement, during the process, and at the end. Non-verbal cues may tell you all you need to know about someone's grasp of the topic.

1. Give information in “bite size” chunks.
2. Put things in a broader context where appropriate.
3. Summarise periodically:
    - During the process - “So far, we've covered . . .”
    - At the end – “Today we have covered…”. Asking learners to summarise is a powerful way of checking their understanding.
4. Reiterate the take home messages.
5. Ask the doctor in training to give you feedback on what has been learnt. This could be incorporated into future educational opportunities.

5.3.4 Developing clinical reasoning skills

The One Minute Preceptor model is a five step process which provides a framework for teaching. Try using it after a doctor in training has presented a case study. The structure encourages doctor to think critically about the case and gives insight into clinical reasoning skills. It also reminds supervisors to provide feedback on performance.



6. Helping the learner in difficulty

Although most doctors in training pass through their early years of training successfully, a small percentage struggle and come to the attention of supervisors. A larger percentage however may have difficulties that are not recognised and can have a significant impact on their satisfaction with career and life if not addressed in a timely and appropriate manner.

There are many definitions in the literature that describe the doctors in training in difficulty: "stressed", "troubled", "distressed", "troublesome", "difficult", "problem doctor", "impaired" "malfunctioning", "poorly performing", "unprofessional" and “poor learner”.

Working as a doctor is stressful. Reports of stress and burnout in doctors are common (Firth-Cozens, 2001; Hulme & Wilhelm, 1994; MJA Supplement, 2002). However, while many doctors in training are “stressed”, fewer become “distressed”, and even fewer have distress impact on their ability to provide quality care.

Similarly, while many doctors in training have “problems” and difficulty with some aspect of their training, only a few will become “problem doctors” or will exhibit major or consistent performance problems. A problem doctor in training can be broadly seen as one who comes to the attention of supervisors.

Supporting a doctor in training with difficulties can be extremely challenging, yet immensely rewarding. Identification and support of doctors in training experiencing difficulties has many parallels with clinical work, and skills may be transferable. This diagnostic process may result in the formulation of a management or intervention plan with the hope of successful remediation in the longer term or referral to colleagues with specialist skills.

Early effective identification, management and prevention are important in:

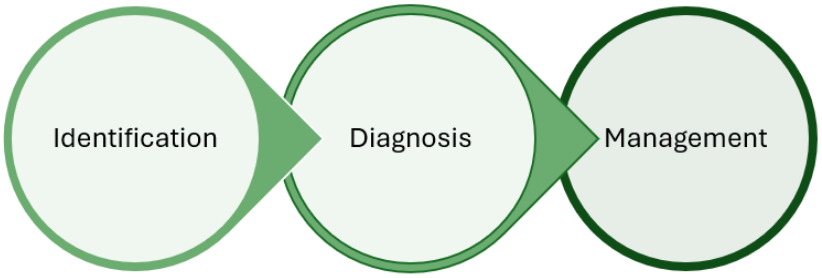
- improving patient outcomes
- reducing self-harm in doctors
- minimising impact on the practice/staff
- reducing dropout from the profession

The regionally based training teams are available to provide support for our supervisors and training posts supporting learners in difficulty.

6.1 Different types of difficulty

In considering ways to best support a doctor in training who is experiencing difficulties, it can be useful to distinguish between three 'categories of difficulty'. The first is a doctor who is failing to make satisfactory progress overall or has areas of specific difficulty with their training. As a supervisor, you are likely to come across doctors in training with difficulties of a transient, more personal nature, who need support for a specific timeframe. Finally, you may also come across doctors in training whom you and others find 'difficult' (the so-called 'difficult doctors in training') because of conduct issues.

Distinguishing between these different types of difficulty involves a diagnostic process, looking for 'signs and symptoms' and gathering 'case' information, before formulating a diagnosis of difficulty and subsequent management plan. As a supervisor, it is often easier to manage the first two situations than the third. It is helpful to distinguish between problems that arise from current circumstances and problems that are related specifically to the personality and behaviour patterns of a doctor in training.



It is helpful to apply a diagnostic process to the doctor in difficulty, in a similar way to other clinical problems, by considering the history, the presenting problem, and the relevant social and employment context.

Reflection

Reflection is an important methodology is facilitating a deeper understanding on effective management of a doctor in training in difficulty. The following questions are useful in enabling this process:

- What difficulties have you encountered when supervising doctors in training?
- How were you alerted to the possible difficulties the doctor in training had?
- Was it an isolated instance or were you aware of a repeating pattern of concerns?
- What information did you need to help the doctor in training?
    - Observations, assessments, appraisals, and reported concerns from others in the team.
- What were the signs and symptoms?

6.2 Identifying the doctor in training in difficulty

Paice (2006) identifies seven key early warning signs that a doctor in training is in difficulty, characterised in terms of observed behavioural patterns. These patterns may relate to behavioural problems *per se* or reflect underlying educational or personal difficulties.

The first step after detecting warning signs in the doctor in training, is to identify an opportunity to share these concerns with the doctor in training, focusing on observable behaviours rather than personal characteristics or traits. An early conversation of this nature may rapidly identify the possible cause(s) of difficulty, which can then be dealt with immediately.

If the problem persists or is of great concern, contact the local regional team representative to receive additional support.

6.3 Approaching the problem

Is there a problem?

The problem may not lie with the doctor in training but with members of staff, patients or other people. Frequently a single event brings the problem to light. Commence gathering evidence by using observation tools and, if appropriate, eliciting feedback from staff, including other supervisors in your team, and patients. Review the evidence. Is this really a problem or does it represent a personality difference between the two individuals?

What is the problem?

Based on observational summations, consider the problem using the categories: clinical competency, professionalism, communication, and personal. Problems are mostly identified by peers, the supervisor or other staff and rarely by the individual.

What is the underlying cause?

Although the presenting performance problem often relates to clinical competence, professionalism, communication or personal, there are usually underlying causes that are contributing and must be dealt with. Commonly the cause is a combination of the doctor in training, the system, and/or the supervisor.

The doctor in training:

- Clinical competency – lack of knowledge (uncommon)
- Professional – unethical
- Communication – lacking skills for communication
- Personal (most common) – depression, drugs and alcohol, financial, family, relationships, cultural.

The supervisor

- Being made to work beyond his/her capacity without support
- Lack of debriefing after critical incidents
- Lack of orientation
- Poor relations between supervisor and doctor in training
- Lack of appraisal and feedback

The practice

- Poor rostering
- Long hours, work overload
- Too many menial tasks

The contribution of each of these factors needs to be considered.

6.4 Management of a problem

Why don't we deal effectively with doctors with problems?

There are many factors that can contribute to suboptimal management of issues.

- Insufficient time
- Fear of reprisals (job loss, bad reference)
- We don't like upsetting people
- Concerned about making the problem worse
- We want an easy life
- We think it may show up our own inadequacies
- We don't want to pass judgement
- We don't think it is our job to do so
- We lack the skill

Identifying problems and causes

Identifying problems and underlying causes means you need to interact with the doctor in training and ensure there are objective, 'assessable' moments on which to base your appraisal, and that you gather information from the appropriate people, including the doctor in training.

Addressing the issue with the doctor

Do this soon after a problem has been identified.

1. Start with 'the quiet chat'.
    a. Obtain their version of any incidents/observations including their version of their performance.
    b. Try to reach a consensus on problem and cause.

2. Negotiate a plan dependant on the problem and underlying cause.
    a. Develop specific criteria for improvement.
    b. Make a timetable for monitoring and frequent appraisal.

3. Consider referral depending on problem or cause.

Documentation and referral

Confidentiality is important. It is essential that supervisors protect the doctor in training's rights and privacy, ensuring a just management process. All supervisors should have access to a clearly outlined pathway to follow for referral that is confidential and independent of career pathways.

Significant issues should be brought to the attention of the appropriate group, including the College, and fully documented. It is recommended making informal notes of events for issues which are likely to resolve in a timely manner which can be referred to at a later date if required.

6.5 Prevention

Consider the categories of causes of problems that you can change such as the supervision arrangements and construct of the system. A good supervisor, a good training program and supportive administration are essential in preventing the doctor in training from developing issues or performing poorly. If problems arise, early identification and effective intervention can help prevent more serious outcomes.

The effective management and support of a doctor in difficulty is complex and approaches adopted will vary depending on the nature of the difficulties faced by the doctor in training and the supervisor's role in training. However, some general principles are relevant for all:

1. Seek to create an open, trusting relationship with all doctors in training, where the interplay between work and life is acknowledged and respected.

2. Know your structures and use them well. A doctor in difficulty is likely to require advice and guidance from a range of people, and, as their supervisor, so will you. This may involve support from your locally based regional team.

3. Keep contemporaneous records of all encounters with the doctor in training in accordance with employer and professional body guidelines.

4. Use appraisals and assessments diagnostically. It is vital that you are explicit about labelling all causes for concern and that these are recorded.

5. Set realistic goals for improvement, monitor these and record outcomes. The importance of ensuring clear feedback, based on observable behaviours and with specific suggestions for improvement cannot be overstated here.

6. Remember that doctors in training in difficulty are also employees in difficulty, who may put patient care or safety at risk. Involve appropriate colleagues with specialist skills within your practice at an early stage and consider whether the College has a support role to play.

7. Don't underestimate the power of regular 'developmental conversations'. These may be with the doctor in training's training mentor who can provide a longer-term sustaining developmental relationship with the doctor in training.

6.6 Support resources for doctors in training in difficulty

ACRRM's Employee Assistance Program: free, immediate confidential, 24/7 phone counselling support for all ACRRM members - 1800 818 728.

Doctors Health Advisory Service: DHAS operates a telephone helpline and are available to provide confidential personal advice to practitioners facing difficulties.

CRANAPlus Bush Crisis Line: This phone counselling service offers support and assistance provided by a trained psychologist, available 24hours/7 days a week. The service is available to all remote and rural health workers including doctors in training and their families that may be in distress every day of the year at 1800 805 391

Beyond Blue: Beyond blue provides free, confidential, 24-7 counselling services for people experiencing mental stress or illness at 1300 22 4636.

7. Further reading

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